Minimum Standards for Psychiatric Residential Care Facilities

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Part I
General

Section A -- Legal Authority

Adoption of Rules, Regulations, and Minimum Standards. By virtue of authority vested in it by Mississippi Code Annotated, 43-11-1 through 43-11-27 (Supplemented 1986), The Mississippi State Department of Health does hereby adopt and promulgate Rules, Regulations, and Minimum Standards for Institutions for the Aged and Infirm which includes Skilled Nursing Facilities, Intermediate Care Facilities, Personal Care Homes.

The 1990 Legislature Amended the code to include Psychiatric Residential Treatment Facilities as an institution for the Aged or Infirm.

"Psychiatric Resident Treatment Facility" means any non-hospital establishment with permanent facilities which provides a twenty-four (24) hour program of care by qualified therapists including, but not limited to, duly licensed mental health professionals, psychiatricts, psychologists and licensed certified social workers, for emotionally disturbed children and adolescents referred to such facility by a court, local school district or by the Department of Human Services, who are not in an acute phase of illness requiring the services of a psychiatric hospital, and are in need of such restorative treatment services. For purposes of this paragraph, the term "emotionally disturbed" means a condition exhibiting one or more of the following characteristics over along period of time and to a marked degree, which adversely affects educational performance:

1. An inability to learn which cannot be explained by intellectual, sensory or health factors;
2. An inability to build or maintain satisfactory relationships with peers and teachers;
3. Inappropriate types of behavior or feelings under normal circumstances;
4. A general pervasive mood of unhappiness or depression; or
5. A tendency to develop physical symptoms or fears associated with personal or school problems.

An establishment furnishing primarily domiciliary care is not within this definition.

Part II
The License

Section A -- Types of License

Regular License. A license shall be issued to each institution for the aged or infirm that meets the requirements as set forth in these regulations. The license shall show the classification (Skilled Nursing Facility, Intermediate Care Facility, Personal Care Home, Psychiatric Residential Treatment Facility).

Provisional License. Within its discretion, the Mississippi State Department of Health may issue a provisional license when a temporary condition of non-compliance with these regulations exists in one or more particulars. A provisional license shall be issued only if the Department of Health is satisfied that preparations are being made to qualify for a regular license and that the health and safety of patients will not be endangered meanwhile. One conditional on which a provisional license may be issued is as follows: A new institution for the aged or infirm may be issued a provisional license prior to opening and subsequent to meeting the required minimum staffing personnel. The license issued under this condition shall be valid until the issuance of a regular license or March 31 following date of issuance whichever may be sooner. A provisional license may be reissued only if it is satisfactorily proven to the Department of Health that efforts are being made to fully comply with these regulations by a specified time.

Section B -- Application for License

Application. Application for a license or renewal of a license shall be made in writing to the licensing agency on forms provided by the Department of Health which shall contain such information as the Department of Health may require. The application shall require reasonable, affirmative evidence of ability to comply with these rules, regulations, and minimum standards.

Fee. In accordance with Section 43-11-7 of the Mississippi Code of 1972, as amended, each application for inital licensure shall be accompanied by a fee of eleven ($11.00) per bed in check or money order made payable to the Mississippi State Department of Health. The fee shall not be refundable after a license has been issued. If the licensure period is less than a full licensure year (April 1 - March 31), the fee shall be pro rated according to the actual days to be covered in the license. Effective July 1, 1986, the fee for licensure renewal shall be eleven dollars ($11.00) per bed in accordance with Section 43-11-9 of the Mississippi Code of 1972, as amended.

Name of Institution. Every institition for the aged or infirm shall be designated by a permanent and distinctive name which shall be used in applying for a license and shall not be changed without first notifying the licensing agency in writing and receiving written approval of the change from the licensing agency. Such notice shall specify the name to be discontinued as well as the new name proposed. The words "hospital", "sanatarium", 'sanatorium", "clinic", or any other word which would reflect a different type of institution shall not appear in the title of an institution for the aged or infirm. In addition to these words, the word "nursing" shall not appear in the title of a Personal Care Home. Only the official name by which the institution is licensed shall be used in telephone listing, on stationery, in advertising, etc. Two or more facilities shall not be licensed under similar names in the same vicinity.

Number of Beds. Each application for licensure shall specify the maximum number of beds in the institition for the aged or infirm. The maximum number of beds for which the facility is licensed shall not be exceeded.

Section C -- Licensing

Issuance of License. All licenses issued by the Department of Health shall set forth the name of the facility, the location, the name of the licensee, the classification of the institution, the type of building, the bed capacity for which the institution is licensed, and the license nubmer.

Posting of License. The license shall be posted in a conspicuous place on the license premises and shall be available for review by an interested person.

License Not Transferable. The license for an institution for the aged or infirm is not transferable or assignable to any other person except by written approval of the licensing agency and shall be issued only for the premises named in the application. The license shall be surrendered to the Department of Health on change of ownership, licensee, name or location of the institution, or in the event that the institution ceases to be operated as an institution for the aged or infirm. In event of change of ownership, licensee, name or location of the institution, a new application shall be filed.

Expiration of License. Each license shall expire on March 31 following the date of issuance.

Renewal of License. License shall be renewable by the licensee.

a. Filing of an application for renewal of licensee.
b. Submission of appropriate licensure renewal fee.
c. Approval of annual report by the licensing agency.
d. Maintenance by the institution of minimum standards in its physical facility, staff, services, and operation as set forth in these regulations.

Section D -- Denial, Suspension, or Revocation of License

Denial or Revocation of License: Hearings and Review. The licensing agency after notice and opportunity for a hearing to the applicant or licensee is authorized to deny, suspend, or revoke a license in any case in which it finds that there has been a substantial failure to comply with the requirements established under the law and these regulations. Also, the following shall be grounds for denial or revocation of license:

a.Fraud on the part of the licensee in applying for a license.
b.Willful or repeated violations by the licensee of any of the provisions of Sections 43-11-1 et seq., of the Mississippi Code of 1972, as amended, and/or the rules, regulations, and minimum standards established by the Department of Health.
c.Addiction to narcotic drug(s) by the licensee or other employees or personnel of the home.
d.Excessive use of alcoholic beverages by the licensee or other personnel of the home to the extent which threatens the well-being or safety of the patient or resident.
e.Conviction of the licensee of a felony.
f.Publicly misrepresenting the home and/or its services.
g.Permitting, aiding, abetting the commission of any unlawful act.
h.Conduct or practices detrimental to the health or safety of patients or residents and employees of said institutions provided that this provision shall not be construed to have any reference to healing practices authorized by law. Detrimental practices include but are not necessarily limited to:
1.Cruelty to patient or resident or indifference to their needs which are essential to their general well-being and health.
2.Misappropriation of the money or property of a patient or resident.
3.Failure to provide food adequate for the needs of the patient or resident.
4.Inadequate staff to provide safe care and supervision of patient or resident.
5.Failure to call a physician when required by patient's or resident's condition.
6.Failure to notify next of kin when patient's or resident's conditions becomes critical.
7.Admission of a patient or resident whose condition demands care beyond the level or care provided by the home as determined by its classification.
i.The execution of any contract for care exceeding one year without written approval of licensing agency.

Section E -- Provision for Hearing and Appeal Following Denial or Revocation of License; Penalties

Administrative Decision. The Mississippi State Department of Health will provide an opportunity for a fair hearing to every applicant or licensee who is dissatisfied with administrative decisions made in the denial or revocation of license.

A.The licensing agency shall notify the applicant or licensee by registered mail or personal service

the particular reasons for the proposed denial or revocation of license. Upon written request of applicant or licensee within ten (10) days of the date of notification the licensing agency shall fix a date not less than thirty (30) days from the date of such service at which time the applicant or licensee shall be given an opportunity for a prompt and fair hearing.

B.On the basis of such hearing or upon default of the applicant or licensee, the licensing agency shall make a determination specifying its findings of fact and conclusions of law. A copy of such determination shall be sent by registered mail to the last known address of the applicant of licensee or served personally upon the applicant or licensee.

C.The decision revoking, suspending, or denying the application or license shall become final thirty (30) days after it is so mailed or served unless the applicant or licensee, within such thirty (30) day period, appeals the decision to the Chancery Court pursuant to Section 12 (6964-12), Chapter 384, Laws 1952. An additional period of time may be granted at the discretion of the licensing agency.

Penalties. Any person establishing, conducting, managing, or operating an instiution for the aged or infirm wiithout a license shall be declared in violations of these regulations and Chapter 451 of the Laws of Mississippi of the Regular Legislative Session of 1979 and subject to the penalties specified in Section 18 thereof.

Part III
Facility Management

Section A -- Governing Body

101.1

Every child/adolescent psychiatric residential treatment facility shall have a governing body that has overall responsibility for the operation of the facility.

A public facility shall have a written description of the administrative organization for the government agency within which it operates.

A public facility shall also have a written description of how the lines of authority within the government agency relate to the governing body of the facility.

A private facility shall have a charter, constitution, or bylaws.

101.2

The names and addresses of all owners or controlling parties of the facility (whether they are individuals; partnerships; corporate bodies; or subdivisions of other bodies, such a public agencies or religious, fraternal, or other charitable organizations) shall be fully disclosed.

In case of corporations, the names and addresses of all officers, directors, and principal stockholders either beneficial or of record shall be disclosed.

010.3

The governing body shall meet at least quarterly.

Minutes of these meetings shall be kept and shall include at least the following:

a. The date of the meeting
b. The names of members who attended
c. The topics discussed
d. The decisions reached and actions taken

e. The dates for implementation of recommendations
f. The reports of the chief executive officer and others.

101.4

The governing body shall establish a committee structure to fulfill its responsibilities and to assess the results of the facility's activities.

101.5

The governing body, through the chief executive officer, shall have a written statement of the facility's goals and objectives, as well as written procedures for implementing these goals and objectives.

There shall be documentation that the statement and procedures are based upon a planning process, and that the facility's goals and objectives are approved by the governing body.

The governing body, through the chief executive officer, shall have a written plan for obtaining financial resources that are consonant with the facility's goals and objectives.

101.6

When a residential treatment program is a component of a larger facility, the staff of the residential treatment program, subject to the overall responsibility of the governing body, shall be given the authority necessary to plan, organize, and operate the program.

The residential treatment program shall hire and assign its own staff. The categorical program shall employ a sufficient number of qualified and appropriately trained staff.

101.7

The governing body, through its chief executive officer, shall develop policies and shall make sufficient resources available (for example, funds, staff, equipment, supplies, and facilities) to assure that the program is capable of providing appropriate and adequate services to patients.

101.8

The facility's physical and financial resources shall be adequately insured.

101.9

The governing body shall establish bylaws, rules and regulations, and a table of organization to guide relationships between itself and the responsible administration and professional staffs and the community.

The governing body may establish one set of bylaws, rules and regulations that clearly delineates the responsibilities and authority of the governing body and the administrative and professional staff.

Administrative and professional staffs may establish separate bylaws, rules and regulations that are consistent with policies established by the governing body.

101.10

All bylaws, rules and regulations shall comply with legal requirements, be designed to encourage high quality patient care, and be consistent with the facility's community responsibility.

101.11

Such bylaws, rules and regulations shall describe the powers and duties of the governing body and its officers and committees; or the authority and responsibilities of any person legally designed to function as the governing body, as well as the authority and responsibility delegated to the responsible administrative and professional staffs.

101.12

Such bylaws, rules and regulations shall state the eligibility criteria for governing body membership; the types of membership and the method of selecting members; frequency of governing body meetings; the number of members necessary for a quorum and other attendance requirements for governing body meetings; the requirement that meetings be documented in the form of written minutes and the duration of appointment or election for governing body members, officers, and committed chairpersons.

101.13

Such bylaws, rules and regulations shall state the eligibility criteria for governing body membership; the types of membership and the method of selecting members; frequency of governing body meetings; the number of members necessary for a quorum and other attendance requirements for governing body meetings; the requirement that meetings be documented in the form of written minutes and the duration of appointment or election for governing body members, officers, and committed chairpersons.

101.14

Such bylaws, rules and regulations shall describe the qualifications, authority, and responsibilities of the chief executive officer.

101.14

Such bylaws, rules and regulations shall specify the method for appointing the chief executive officer.

101.15

Such bylaws, rules and regulations shall provide the administrative and professional staffs with the authority and freedom necessary to carry out their responsibilities within the organizational framework of the facility.

2701.16

Such bylaws, rules and regulations shall provide the professional staff with the authority necessary to encourage high quality patient care.

2701.17

Such bylaws, rules and regulations shall state the procedures under which the administrative and professional staff cooperatively function.

2701.18

Such bylaws, rules and regulations shall require the establishment of controls designed to encourage each member of the professional staff to observe the standards of the profession and assume and carry out functions in accordance with local, state,a nd federal laws and rules and regulations.

2701.19

Such bylaws, rules and regulations shall require the professional staff bylaws, rules and regulations to be subject to governing body approval.

2701.20

Such bylaws, rules and regulations shall specify procedures for selecting professional staff

officers,directors, and department or service chiefs.

2701.21

Such bylaws, rules and regulations shall require that physicians with appropriate qualifications, licenses, and clinical privileges evaluate and authenticate medical histories and physical examinations, and prescribe medications.

2701.22

Such bylaws, rules and regulations may also allow dentists with appropriate qualifications, licenses, and clinical privileges to prescribe medications.

2701.23

Such bylaws, rules and regulations shall describe the procedure for conferring clinical privileges on all professional staff.

2701.24

Such bylaws, rules and regulations shall define the responsibilities of physicians in relation to non-physician members of the professional staff.

2701.25

Such bylaws, rules and regulations shall provide a mechanism through which the administrative and professional staffs report to the governing body.

2701.26

Such bylaws, rules and regulations shall define the means by which the administrative and professional staffs participate in the development of facility and program policies concerning program management and patient care.

2701.27

Such bylaws, rules and regulations shall require an orientation program for new governing body members and a continuing education program for all members of the governing body.

2701.28

Such bylaws, rules and regulations shall require that the bylaws, rules and regulations be reviewed at least every two years, revised as necessary, and signed and dated to indicate the time of last review.

2702 -- Chief Executive Officer

2702.1

The governing body shall appoint a chief executive officer who shall be employed on a full-time basis.

2702.2

The qualifications, authority, and duties of the chief executive officer shall be stated in the governing body's bylaws, rules and regulations.

2702.3

The chief executive officer shall be a health professional with appropriate professional qualifications and experience, including previous administrative responsibility in a health facility.

2702.4

The chief executive officer shall have a medical degree or at least a master's degree in administration, psychology, social work, education, or nursing; and, when required, should have appropriate licenses. Experience shall include previous administrative responsibility in a facility for children or adolescents. Experience may be substituted for a professional degree when it is carefully evaluated, justified, and documented by the governing body.

2702.5

In facilities primarily serving children or adolescents, the chief executive officer shall have appropriate professional qualifications and experience, including previous administrative responsibility in a facility for children or adolescents.

2702.6

In accordance with the facility's bylaws, rules and regulations, the chief executive officer shall be responsible to the governing body for the overall operation of the facility, including the control, utilization, and conservation of its physical and financial assets and the recruitment and

direction of staff.

2702.7

The chief executive officer shall assist the governing body in formulating policy by preparing the following items and presenting them to and reviewing them with the governing body:

a. Long-term and short-term plans of the facility.
b. Reports on the nature and extent of funding and other available resources.
c. Reports describing the facility's operations.
d. Reports evaluating the efficiency and effectiveness of facility or program activity.
e. Budgets and financial statements.

2702.8

The chief executive officer shall be responsible for the preparation of a written manual that defines the facility policies and procedures and that is regularly revised and updated.

2702.9

There shall be documentation that the chief executive officer attends and participates in continuing education programs.

2703 -- Professional Staff Organization

2703.1

There shall be a single organized professional staff that has the overall responsibility for the quality of all clinical care provided to patients, and for the ethical conduct and professional practices of its members, as well as for accounting therefor to the governing body. The manner in which the professional staff is organized shall be consistent with the facility's documented staff organization and bylaws, rules and regulations, and pertain to the setting where the facility is located. The professional staff bylaws,rules and regulations, and the rules and regulations of the governing authority shall require that a qualified physician be responsible for diagnosis and all care and treatment. The organization of the professional staff, and its bylaws, rules and regulations, shall be approved by the facility's governing body.

2703.2

The professional staff shall strive to assure that each member is qualified for membership and

shall encourage the optimal level of professional performance of its members through the appointment/reappointment procedure, the specific delineation of clinical privileges, and the periodic reappraisal of each staff member according to the provisions.

2703.3 -- **Qualifications**

2703.4

The appointment and reappointment of professional staff members shall be based upon well-defined, written criteria that are related to the goals and objectives of the facility as stated in the bylaws, rules and regulations of the professional staff and of the governing body.

2703.5

Upon application or appointment to the professional staff, each individual must sign a statement to the effect that he or she has read and agrees to be bound by the professional staff and governing body bylaws, rules and regulations.

2703.6

The initial appointment and continued professional staff membership shall be dependent upon clinical competence and ethical practice in keeping with the qualifications, standards, and requirements set forth in the professional staff and governing body bylaws, rules and regulations.

2703.7

Unless otherwise provided by law, only those practitioners who are licensed, certified, or registered, or who have demonstrated competence and experience, shall be eligible for professional staff membership.

2703.8 -- **Method of Selection**

2703.9

Each facility is responsible for developing a process of appointment to the professional staff whereby it can satisfactorily determine that the person is appropriately licensed, certified, registered, or experienced, and qualified for the privileges and responsibilities he or she seeks.

2703.10 -- **Privilege Delineation**

2703.11

Privileges shall be delineated for each member of the professional staff, regardless of the size of the facility.

2703.12

The delineation of privileges shall be based on all verified information available in the applicant's or staff member's credentials file.

2703.13

Clinical privileges shall be facility-specific.

2703.14

The professional staff shall delineate in its bylaws, rules and regulations of the qualifications, status, clinical duties, and responsibilities of clinical practitioners who are not members of the professional staff but who services require that they be processed through the usual professional staff channels.

2703.15

The training, experience, and demonstrated competence of individuals in such categories shall be sufficient to permit their performing their assigned functions.

2703.16

There shall be provisions for individuals in such categories to receive professional supervision, when indicated, from their professional counterparts.

2703.17 -- **Reappointment**

2703.18

The facility's professional staff bylaws, rules and regulations shall provide for review and reappointment of each professional staff member at least once every two years.

2703.19

The reappointment process should include a review of the individual's status by a designated professional staff committee, such as the credentials committee.

2703.20

When indicated, the credentials committee shall require the individual to submit evidence of his or her current health status that verifies the individual's ability to discharge his or her responsibilities.

2703.21

The committee's review of the clinical privileges of a staff member for reappointment should include the individual's past and current professional performance as well as his or her adherence to the governing body and professional staff bylaws, rules and regulations.

2703.22

The professional staff bylaws,rules and regulations shall limit the time within which the professional staff reappointment and privilege delineation processes must completed.

2703.23 -- **Organization**

2703.24

The professional staff shall be organized to accomplish its required functions. The professional staff organization must provide a framework in which the staff can carry out its duties and functions effectively. The complexity of the organization shall be consonant with the size of the facility and the scope of its activities.

2703.25

The professional staff bylaws, rules and regulations shall provide for the selection of officers for an executive committee, and , when appropriate, for other organizational components of the facility.

2703.26

The professional staff bylaws, rules and regulations should specify the organization needed to provide effective governance of the professional staff.

2703.27 -- **Executive Committee**

2703.28

The executive committee shall be empowered to act for the professional staff in the intervals between the staff meetings.

2703.29

The committee shall serve as a liaison mechanism between the professional staff and the administration.

2703.30

There shall be a mechanism that assures medical participation in the deliberations of the executive committee.

2703.31

The professional staff bylaws, rules and regulations shall define the size, composition, method of selecting members, and frequency of meetings of the executive committee.

2703.32

The executive committee shall maintain a permanent record of its proceedings and actions.

2703.33

The functions and responsibilities of the executive committee shall include at least the following:

a. receiving and acting upon reports and recommendations from professional staff committees, departments, and services.
b. implementing the approved policies of the professional staff.
c. recommending to the governing body all matters relating to appointments and reappointments, staff categorization and assignments, clinical privileges, and except when such is a function of the professional staff or one of its committees, corrective action.
d. fulfilling the professional staff's accountability to the governing body for the quality of the overall clinical care rendered to patients in the facility; and
e. initiating and pursuing corrective action when warranted, in accordance with the provisions of the professional staff bylaws, rules and regulations.

2703.34 -- **Professional Staff Bylaws**

2703.35

The professional staff shall develop and adopt bylaws, rules and regulations to establish a framework of self-government and a means of accountability to the governing body.

2703.36

The bylaws,rules and regulations shall be subject to the approval of the governing body.

2703.37

The professional staff shall regulate itself by its bylaws, rules and regulations.

2703.38

The professional staff bylaws, rules and regulations shall reflect current staff practices, shall be enforced, and shall be periodically reviewed and revised as necessary.

2703.39

The professional staff bylaws, rules and regulations shall include a requirement for an ethical pledge from each practitioner.

2703.40

The professional staff bylaws, rules and regulations shall describe the specific role of each discipline represented on the professional staff or exercising clinical privileges in the care of patients.

2703.41

The professional staff bylaws, rules and regulations shall include the following patient record requirement:

a. Symbols and abbreviations shall be used only when they have been approved by the professional staff and when there is an explanatory legend;
b. The categories of personnel who are qualified to accept and transcribe verbal orders, regardless of the mode of transmission of the orders, shall be specifically identified;
c. The period of time following admission to the facility within which a history and physical examination must be entered in the patient record shall be specified;
d. The time period in which patient records must be completed following discharge shall be specified and shall not exceed fourteen (14) days; and

e. The entries in patient records that must be dated and authenticated by the responsible practitioner shall be specified.

2703.42

The professional staff bylaws, rules and regulations shall specify mechanisms for review, evaluation, and monitoring of professional staff practices.

2703.43

The professional staff bylaws, rules and regulations shall specify mechanisms for the denial of staff appointments and reappointments, as well as for denial, curtailment, suspension, or revocation of clinical privileges.

When appropriate, this procedure shall provide for a practitioner to be heard, upon request, at some stage of the process.

2704 -- Written Plan for Professional Services

2704.1

The facility shall formulate and specify in a written plan for professional services its goals, objectives, policies, and programs so that its performance can be measured.

2704.2

The plan shall describe the services offered by the facility so that a frame of reference for judging the various aspects of the facility's operation is available.

2704.3

The written plan for professional services shall describe the following:

a. the population served, including age groups and other characteristics of the patient population;
b. the hours and days the facility operates;
c. the methods used to carry out initial screening and/or triage;
d. the intake or admission process; including how the initial contact is made with the patient and the family or significant others;
e. the assessment and evaluation procedures provided by the facility;
f. the methods used to deliver services to meet the identified clinical needs of patients

served;

g. the basic therapeutic programs offered by the facility;
h. the treatment planning process and the periodic review of therapy;
i. the discharge and post-therapy planning processes;
j. the organizational relationships of each of the facility's therapeutic programs, including channels of staff communication, responsibility, and authority, as well as supervisory relation-ships; and
k. the means by which the facility provides, or makes arrangements for the provision of, the following:

1. other medical, special assessments, and therapeutic services;
2. patient education services, whether provided from within or outside the facility;
3. emergency services and crisis intervention; and
4. discharge and aftercare, including post-therapy planning and follow-up evaluation.

2704.4

When the facility is organized by departments or services, the written plan for professional services shall describe how each department or service relates to the goals and other programs of the facility, specify lines of responsibility within each department of service, and define the rolls of department or service personnel and the methods for interdisciplinary collaboration.

2704.5

When a facility is organized on a team or unit basis, either totally or in part, the written plan for professional services shall delineate the roles and responsibilities of team members in meeting the identified clinical needs of patients and in relation to the goals and programs of the facility.

2704.6

The written plan for professional services shall be made known and available to all professional personnel and to the chief executive officer.

2704.7

The plan shall be reviewed at least annually, and revised as necessary, in relation to the changing needs of the patients, the community, and the overall objectives and goals of the facility, and it shall be signed and dated by the reviewers.

2704.8

Within the scope of its activities, the facility shall have enough appropriately qualified health care professional, administrative and support staff available to adequately assess and address the identified clinical needs of patients.

Appropriately qualified professional staff may include qualified child and/or adolescent psychiatrists and other physicians, clinical psychologists, social workers, psychiatric nurses, and other health care professionals in numbers and variety appropriate to the services offered by the facility and with training and experience working with children and/or adolescents.

2704.9

When appropriate qualified professional staff are not available or needed on a full-time basis, arrangements shall be made to obtain sufficient services on an attending continuing consultative, or part-time basis.

2704.10

The professional staff shall include, but not be limited to, the following appropriately qualified mental health professionals and paraprofessionals; child psychiatrists; child psychologists; social workers; psychiatric nurse; child care workers; educators; speech, hearing, and language specialists; activity and recreation specialists; and vocational counselors.

2704.11

The professional staff, who are assigned full time to the child/adolescent psychiatric residential treatment program are not shared with other programs.

2704.12

The staff shall be specially trained to meet the needs of adolescents and children.

2704.13

There shall be documentation to verify that health care professional staff meet all federal, state, and local requirements for licensing, registration, or certification.

2705 **-- Staff Composition**

2705.1 -- **Psychiatric Services**

2705.2

Psychiatric services are under the supervision of a clinical director, service chief or equivalent licensed physician who is qualified to provide the leadership required for an intensive treatment program.

2705.3

The director shall be certified by the American Board of Psychiatry and Neurology, or meet the training and experience requirements for examination by the Board (Board eligible). In the event the psychiatrist in charge of the clinical program is Board eligible, there is evidence of consultation given to the clinical program on a continuing basis from a psychiatrist certified by the American Board of Psychiatry and Neurology.

2705.4

The number of psychiatrists is commensurate with the size and scope of the treatment program.

2705.5

All psychiatrists shall be licensed in the State of Mississippi.

2705.6 -- **Medical Services**

2705.7

Physicians shall be available at all times to provide necessary medical and surgical diagnostic and treatment services, including specialized services.

2705.8

If medical surgical diagnosis and treatment services are not available within the facility, qualified consultants or attending physicians are immediately available or arrangements are made to transfer patients to a general hospital.

2705.9 -- **Nursing Services**

2705.10

Nursing services shall be under the direct supervision of a registered nurse who has had at least two (2) years of experience in psychiatric or mental health nursing and at least one (1) year of experience in a supervisory position.

2705.11

The number of registered professional nurses, licensed practical nurses, and other nursing personnel shall be adequate to formulate and carry out the nursing components of the individual treatment plan for each patient.

2705.12

There shall be a registered professional nurse on duty 24 hours a day, seven days a week, to plan, assign, supervise, and evaluate nursing care, and to provide for the delivery of nursing care to patients.

2705.13 -- **Psychological Services**

2705.14

Patients shall be provided psychological services, in accordance with their needs by a qualified psychologist.

Services to patients include evaluations, consultations, therapy and program development.

A qualified psychologist is an individual licensed by the State Board of Psychological Examiners with a specialty area in Clinical or Counseling Psychology (refer to Mississippi Code of 1972, annotated and amended, Section 73-31-10).

2705.15 -- **Social Services**

2705.16

Social work services are under the supervision of a licensed qualified social worker.

The director of the service or department shall have a master's degree from an accredited school of social work, or have been certified by the Academy of Certified Social Workers.

2705.17

Social work staff is qualified and numerically adequate to provide the following services:

a. Psychosocial data for diagnosis and treatment planning.
b. Direct therapeutic services to individual patients, patient groups or families.
c. Develop community resources.
d. Participate in interdisciplinary conferences and meetings concerning treatment planning, including identification and utilization of other facilities and alternative forms of care and treatment.

2705.18 -- **Rehabilitative Services**

2705.19

Qualified therapists, consultants, assistants or aides are sufficient in number to provide comprehensive therapeutic activities, including at least occupational, recreational and physical therapy as needed, to assure that appropriate treatment is rendered for each patient, and to establish and maintain a therapeutic milieu.

a. Occupational therapy services are prescribed by a physician and provided to a patient by or under the direction of a qualified occupational therapist.

A qualified occupational therapist is an individual who is registered by the American Occupational Therapy Association; or is a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required

106.32 -- **Educational Services**

106.33

Educational and vocational services available to patients of the psychiatric residential treatment facility shall, at a minimum, meet the requirements of the state law with regard to compulsory education. Compulsory education services may be provided directly by the residential treatment facility or may be provided by written agreement with the local school district. In any case, compulsory education services must be available either on the same site or in close physical proximity to the psychiatric residential treatment facility.

Appropriate written agreements among the State Department of Education, all respective local school districts and the psychiatric residential treatment facility shall be made regarding the provision of educational services for those youths not eligible to be ruled "emotionally handicapped" under this State's Department of Educational's referral to placement regulations and guidelines for handicapped children and youth.

106.34

When compulsory education services are provided directly by the residential treatment facility, such services shall comply with the regulations of the State Board of Education. In such case,the psychiatric residential treatment facility shall comply with all appropriate requirements for the education of handicapped patients.

106.35

Educational services shall be provided by licensed teachers who shall have at least a bachelor's degree in education from an accredited institution, shall have certification in special education, and preferably shall have training in the education of emotionally disturbed children/adolescents.

Section G -- Personnel Policies and Procedures

107.1

Personnel policies and procedures shall be developed in writing, adopted, and maintained to promote the objectives of the facility and to provide for an adequate number of qualified personnel during all hours of operation to support the functions of the facility and the provision of high quality care.

All personnel policies shall be reviewed and approved on an annual basis by the governing body.

There shall be documentation to verify that the written personnel policies and procedures are explained and made available to each employee.

The policies and procedures shall include a mechanism for determining that all personnel are medically and emotionally capable of performing assigned tasks and are free of communicable and infectious diseases.

107.2

There shall be written policies and procedures for handling cases of patient neglect and abuse.

The policies and procedures on patient neglect or abuse shall be given to all personnel. Any alleged violations of these policies and procedures shall be investigated, and the results of such investigation shall be reviewed and approved by the director and reported to the governing body.

107.3

A personnel record shall be kept on each staff member and shall contain the following items, as appropriate:

a. Application for employment
b. Written references and a record of verbal references
c. Verification of all training and experience, and licensure, certification, registration and/or renewals
d. Wage and salary information
e. Performance appraisals
f. Initial and subsequent health clearances
g. Disciplinary and counseling actions
h. Commendations
i. Employee incident reports
j. Record of orientation to the facility, its policies and procedures and the employee's

position.

107.4

For each position in the facility, there shall be a written job description that specifies the duties and responsibilities of the position and the minimum level of education, training, and/or related work experience required or needed to fulfill it.

Section H **-- Staff Development**

108.1

The facility shall have a written plan of evidence of implementation of a program of staff development and inservice training that is consonant with the basic goals and objectives of the program.

108.2

Staff development shall be under the supervision and direction of a committee or qualified person. This person or committee may delegate responsibility for any part of the program to appropriately qualified individuals.

108.3

The staff development plan shall include plans for orientation of new employees and shall specify subject areas to be covered in the orientation process.

108.4

Staff development program shall reflect all administrative and service changes in the facility and shall prepare personnel for promotions and responsibilities.

108.5

A continuous professional education program shall be provided to keep the professional staff informed of significant clinical and administrative developments and skills.

108.6

The facility shall provide continuing training for all staff and specific orientation for all new

personnel in the principles of confidentiality, privacy, patients' rights, infection control, fire prevention, disaster preparedness, accident prevention and patient safety.

108.7

Specialized training shall be provided for staff working with children and adolescents.

108.8

The facility shall have documentation of the staff development, inservice training and orientation activities of all employees.

Section I **-- Patient Rights**

109.1

The facility shall support and protect the fundamental human, civil, constitutional, and statutory rights of each patient.

109.2

The facility shall have written policies and procedures that describe the rights of patients and the means by which these rights are protected and exercised. These rights shall include the following:

a. Each patient shall have impartial access to treatment, regardless of race, religion, sex, ethnicity, age, or handicap.
b. Each patient's personal dignity shall be recognized and respected in the provision of all care and treatment.
c. Each patient shall receive individualized treatment, which shall include at least the following:

    1. the provision of adequate and human services, regardless of source(s) of financial support;
    2. the provision of services within the least restrictive environment possible;
    3. the provision of an individual treatment plan;
    4. the periodic review of the patient's treatment plan'
    5. the active participation of patients over 12 years of age and their responsible parent, relative, or guardian in planning for treatment; and
    6. the provision of an adequate number of competent, qualified, and experienced professional clinical staff to supervise and implement the treatment plan.

d. Each patient's personal privacy shall be assured and protected within the constraints of the individual treatment plan.

1. The patient's family and significant others, regardless of their age, shall be allowed to visit the patient, unless such visits are clinically contraindicated.
2. Suitable areas shall be provided for patients to visit in private, unless such privacy is contraindicated by the patient's treatment plan.
3. Patients shall be allowed to send and receive mail without hindrance.
4. Patients shall be allowed to conduct private telephone conversations with family and friends, unless clinically contraindicated.
5. If therapeutic indications necessitate restrictions on visitors, telephone calls, or other communications, those restrictions shall be evaluated for therapeutic effectiveness by the clinically responsible staff at least every seven days.
6. If limitations on visitors, telephone calls, or other communications are indicated for practical reasons (for example, expense of travel or phone calls) such limitations shall be determined with the participation of the patient and the patient's family. All such restrictions shall be fully explained to the patient and the patient's family.

e. Each patient has the right to request the opinion of a consultant at this or her expense or to request an inhouse review of the individual treatment plan, as provided in specific procedures of the facility.

109.3

Each patient shall be informed of his or her rights in a language the patient understands.

109.4

Each patient shall receive a written statement of patient rights, and a copy of this statement shall be posted in various areas of the facility.

109.5

As appropriate, the patient, the patient's family, or the patient's legal guardian shall be fully informed about the following items:

a. the rights of patients;
b. the professional staff members responsible for his or her care, their professional status, and their staff relationship;
c. the nature of the care; procedures, and treatment that he or she will receive;

d. the current and future use and disposition of products of special observation and audiovisual techniques, such as one-way vision mirrors, tape recorders, television, movies, or photographs;
e. The risks, side effects; and benefits of all medications and treatment procedures used, especially those that are unusual or experimental;
f. the alternate treatment procedures that are available;
g. the right to refuse to participate in any research project without compromising his or her access to facility services;
h. the right, to the extent permitted by law, to refuse specific medications or treatments procedures;
i. the responsibility of the facility, when the patient refuses treatment, to seek appropriate legal alternatives or orders of involuntary treatment, or, in accordance with professional standards, to terminate the relationship with the patient upon reasonable notice;
j. as appropriate, the cost, itemized when possible, of services rendered;
k. the source of the facility's reimbursement, and any limitations placed on duration of services;
l. the reasons for any proposed change in the professional staff responsible for the patient, or for any transfer of the patient either within or outside of the facility;
m. the rules and regulations of the facility applicable to his or her conduct;
n. the right to initiate a complaint or grievance procedure and the appropriate means of requesting a hearing or review of the complaint;
o. the discharge plans; and
p. the plans for meeting continuing mental and physical health requirements following discharge

109.6

In accordance with the requirements of any applicable law or any other applicable standard in this manual, a written, dated, and signed informed consent from shall be obtained from the patient, the patient's family, or the patient's legal guardian, as appropriate, for participation in any research project and for use or performance of the following:

a. surgical procedures;
b. electroconvulsive therapy;
c. unusual medications;
d. hazardous assessment procedures;
e. audiovisual equipment; and
f. other procedures where consent is required by law.

109.7

The maintenance of confidentiality of communications between patients and staff and of all

information recorded in patient records shall be the responsibility of all staff. (Refer to the patient records section of this manual).

The facility shall provide continuing training for all staff and specific orientation for all new personnel in the principles of confidentiality and privacy.

109.8

The patient shall be allowed to work for the service provider only under the following conditions:

a. the work is part of the individual treatment plan;
b. the work is performed voluntarily;
c. the patient receives wages commensurate with the economic value of the work; and
d. the work project complies with local, state, and federal laws and regulations.

Section J **-- Special Treatment Procedures**

110.1

Treatment procedures that require special justification shall include, but not necessarily be limited to, the following:

a. the use of restraint;
b. the use of seclusion;
c. the use of electroconvulsive therapy and other forms of convulsive therapy;
d. the performance of psychosurgery of other surgical procedures for the intervention in, or alteration of, a mental, emotional, or behavioral disorder;
e. the use of behavior modification procedures that use painful stimuli;
f. the use of unusual medications and investigational and experimental drugs;
g. the prescribing and administering of drugs for maintenance use that have abuse potential (usually considered to be Schedule II drugs),and drugs that are known to involve substantial risk or to be associated with undesirable side effects; and
h. the use of research projects that involve inconvenience or risk to the patient.

110.2

The rationale for using special treatment procedures shall be clearly stated in the patient's record.

When appropriate, there shall be evidence in the patient's record that proposed special treatment procedures have been reviewed before implementation by the head of the professional staff and or his or her designee.

The plan for using special treatment procedures shall be consistent with the patient's rights and the facility's policies governing the use of such procedures.

The clinical indications for the use of special treatment procedures shall be documented in the patient's record.

The clinical indications for the use of special treatment procedures shall outweigh the known contraindications.

110.3

The facility shall have written policies and procedures that govern the use of restraint or seclusion.

The use of restraint or seclusion shall require clinical justification and shall be employed only to prevent a patient from injuring himself or others, or to prevent serious disruption of the therapeutic environment. Restraint or seclusion shall not be employed as punishment or for the convenience of staff.

The rationale for the use of restraint or seclusion shall address the inadequacy of less restrictive intervention techniques.

To ascertain that the procedure is justified, a physician shall conduct a clinical assessment of the patient before writing an order for the use of restraint or seclusion.

A written order from a physician shall be required for the use of restraint.

A written order from a physician shall be required for the use of seclusion for longer than one hour.

Written orders for the use of restraint or seclusion shall be time-limited.

The written approval of the head of the professional staff and/or his or her designee shall be required when restraint or seclusion is utilized for longer than 24 hours.

PRN orders shall not be used to authorize the use of restraint or seclusion.

All uses of restraint or seclusion shall be reported daily to the head of the professional staff and/or his or her designee.

The head of the professional staff and/or his or her designee shall review daily all uses of restraint or seclusion and investigate unusual or possibly unwarranted patterns of utilization.

Staff who implement written orders for restraint and seclusion shall have documented training in the proper use of the procedure for which the order was written.

Restraint or seclusion shall not be used in a manner that causes undue physical discomfort, harm, or pain to the patient.

Appropriate attention shall be paid every 15 minutes to a patient in restraint or seclusion, especially in regard to regular meals, bathing, and use of the toilet.

There shall be documentation in the patient's record that such attention was given to the patient.

Under the following conditions, restraint or seclusion may be employed in an emergency without a written order from a physician:

a. the written order for restraint or seclusion is given by a member of the professional staff who is qualified by experience and training in the proper use of the procedure for which the order is written.
b. the professional staff member writing the order has observed and assessed the patient before writing the order; and
c. the written order of the physician who is responsible for the patient's medical care is obtained within not more than eight hours after initial employment of the restraint or seclusion.

110.4

The facility shall have written policies and procedures that govern the use of time-out and the documentation of such procedures in the case record.

The use of time-out shall require clinical justification and shall not be employed for the convenience of staff.

Time-out procedures shall meet the following requirements:

a. A child/adolescent placed in time-out shall be under visual observation at intervals of fifteen minutes or less while in time-out; and
b. A locked door shall not be a component of time-out; and
c. Time-out shall be limited to a maximum of thirty minutes at one time for a child age ten years or under and shall be limited to a maximum of sixty minutes at one time for an adolescent age eleven years or older; and
d. No child/adolescent shall be in time-out for more than four hours in any 24 hour period.

110.5

Electroconvulsive (or other forms of convulsive therapies) shall not be administered in a child/adolescent psychiatric residential treatment facility but may be administered in an acute care medical or psychiatric hospital.

110.6

The facility shall have policies that prohibit the performance of psychosurgery or other surgical procedures for the intervention in, or alteration of, a mental, emotional, or behavioral disorder in children or adolescents.

110.7

Behavior modification procedures that use painful stimuli shall be documented in the patient's record.

110.8

The written informed consent of the patient for the use of behavior modification procedures that use painful stimuli shall be obtained and made part of the patient's record. The patient may withdraw consent at any time.

When required, the written informed consent of the family and/or legal guardian shall be obtained and made part of the patient's record. The family and/or guardian may withdraw consent at any time.

In cases dealing with children or adolescents, the responsible parent(s), relative, or guardian and, when appropriate, the patient shall give written, dated, and signed informed consent. The family and/or guardian and, when appropriate, the child or adolescent patient may withdraw consent at any time.

110.9

The facility shall have written policies and procedures that govern the use of unusual medications and investigational and experimental drugs.

Unusual or experimental drugs shall be reviewed before use by the research review committee, the patient rights' review committee, or another appropriate peer review committee.

Investigational drugs shall be used only under the direct supervision of the principal investigator and with the approval of the physician members of the professional staff or an appropriate committee of the professional staff, the research review committee, and appropriate federal, state, and local agencies.

110.10

A central unit shall be established to maintain essential information on investigational drugs, such as drug dosage form, dosage range, storage requirements, adverse reactions, usage, and contraindications.

110.11

Investigational drugs shall not be administered to children or adolescents in a residential treatment facility, unless approved in writing by the State Board of Health on a case by case basis.

110.12

Nurses may administer investigational drugs only after receiving basic pharmacologic information about the drugs.

110.13

The written informed consent of the patient for the use of unusual medications or investigational or experimental drugs shall be obtained and made part of the patient's record. The patient may withdraw consent at any time.

When required, the written informed consent of the family and/or legal guardian for the use of unusual medication or investigational or experimental drugs shall be obtained and made part of the patient record. The family and/or guardian may withdraw consent at any time.

In cases dealing with children and adolescents, the responsible parent(s), relative, or guardian and, when appropriate, the patient shall give written, dated, and signed informed consent, unless prohibited by law. The family and/or guardian and, when appropriate, the child or adolescent patient may withdraw consent at any time.

The denial of consent to take unusual medications of investigational or experimental drugs shall not be cause for denying or altering services indicated for the patient.

110.14

The facility shall have written policies and procedures that govern the prescribing and administering of drugs for maintenance use that have abuse potential (usually considered to be Schedule II drugs), and drugs that are known to involve a substantial risk or be associated with undesirable side effects.

Drugs that have abuse potential shall be prescribed and administered for maintenance use only when the following criteria are met:

1. a physician member of the professional staff has reviewed the patient's record and has recorded the reasons for prescribing the drug(s) in the patient's record;
2. the prescribed drug is listed in the facility's formulary; and
3. prior to the administration of the drug, the patient and, when required by law,the patient's parent(s) or guardian are informed orally and in writing, and, if possible, in the patient's native language, of the benefits and hazards of the drug.

110.15

The facility shall have written policies and procedures that protect the rights of patients involved in research projects that involve inconvenience or risk to the patient.

Section K **-- Patient Records**

111.1

A patient record shall be maintained, in accordance with accepted professional principles, for each patient admitted for care in the facility.

111.2

Such records shall be kept confidential and only authorized personnel shall have access to the record. Staff members and other persons having access to patient records shall be required to abide by the written policies regarding confidentiality of patient records and disclosure of information in the record, as well as all applicable federal, state, and local laws, rules and regulations.

111.3

The facility shall have written policies and protect the confidentiality of patient records and govern the disclosure of information in the records. The policies and procedures shall specify the conditions under which information on applicants or patients may be disclosed and the procedures for releasing such information.

111.4

A patient of his or her authorized representative may consent to the release of information

provided that written consent is given on a form containing the following information:

a. name of patient
b. name of program
c. the name of the person, agency or organization to which the information is to e disclosed
d. the specific information to be disclosed
e. the purpose for the disclosure
f. the date the consent was signed and the signature of the individual witnessing the consent
g. the signature of the patient, parent, guardian or authorized representative; and
h. a notice that the consent is valid only for a specified period of time.

111.5

The written consent of a patient, or his or her authorized representative, to the disclosure of information shall be considered valid only if the following conditions have been met:

a. the patient or the representative shall be informed, in a manner calculated to assure his or her understanding, of the specific type of information that has been requested and, if known, the benefits and disadvantages of releasing the information;
b. the patient or the representative shall give consent voluntarily;
c. the patient or the representative shall be informed that the provision of services is not contingent upon his or her decision concerning the release of information; and
d. the patient's consent shall be acquired in accordance with all applicable federal, state, and local laws, rules and regulations.

111.6

Every consent for release of information, the actual date the information was released, the specific information released, and the signature of the staff member who released the information shall be made a part of the patient record.

111.7

In a life-threatening situation or when an individual's condition or situation precludes the possibility of obtaining written consent, the facility may release pertinent medical information to the medical personnel responsible for the individual's care without the individual's consent and without the authorization of the chief executive officer or a designee, if obtaining such authorization would cause an excessive delay in delivering treatment to the individual.

When information has been released under emergency conditions, the staff member responsible

for the release of information shall enter all pertinent details of the transaction into the individual's record including at least the following items:

a. the date the information was released;
b. the person to whom the information was released;
c. the reason the information was released;
d. the reason written consent could not be obtained; and
e. the specific information released.

The patient or applicant shall be informed that the information was released as soon as possible after the release of information.

111.8

Patient records shall not be removed from the facility except upon subpoena and court order.

111.9 -- **Preservation and Storage**

111.10

Records shall be preserved, either in the original or by microfilm, for a period of time not less than that determined by the statue of limitations in the State of Mississippi.

111.11

Written policies and procedures shall govern the compilation, storage, dissemination, and accessibility of patient records. The policies and procedures shall be designed to assure that the facility fulfills its responsibility to safeguard and protect the patient record against loss, unauthorized alteration, or disclosure of information; to assure that each patient record contains all required information; to uniformity in the format and forms in use in patient records; to require entries in patient records to be dated and signed.

111.12

The facility shall provide adequate facilities for the storage, processing, and handling of patient records, including suitably locked and secured rooms and files. When a facility stores patient data on magnetic tape, computer files, or other types of automated information systems, adequate security measures shall prevent inadvertent or unauthorized access to such data. A written policy shall govern the disposal of patient records. Methods of disposal shall be designed to assure the confidentiality of information in the records.

111.13 -- **Personnel**

111.14

The patient records department shall maintain, control, and supervise the patient records, and shall be responsible for maintaining the quality.

111.15

A qualified medical record individual who is employed on at least a part-time basis, consistent with the needs of the facility and the professional staff, shall be responsible for the patient records department. This individual shall be a registered record administrator or an accredited record technician.

111.16

When it can be demonstrated that the size, location, or needs of the facility must secure the consultative assistance of a registered record administrator at least twice a year to assure that the patient record department is adequate to meet the needs of the facility.

111.17 -- **Centralization of Reports**

111.18

All clinical information pertaining to a patient's stay shall be centralized in the patient's record. The original or all reports originating in the facility shall be filed in the medical record. Appropriate patient records shall be kept on the unit where the patient is being treated and shall be directly accessible to the clinician caring for the patient.

111.19 -- **Content of Records**

111.20

The medical record shall contain sufficient information to justify the diagnosis and warrant the treatment and end results. The patient record shall describe the patient's health status at the time of admission, the services provided and the patient's progress in the facility, and the patient's health status at the time of discharge. The patient record shall provide information for the review and evaluation of the treatment provided to the patient. When appropriate, data in the patient record shall be used in training, research, evaluation, and quality assurance programs. When indicated, the patient record shall contain documentation that the rights of the patient and of the

patient's family are protected.The patient record shall contain documentation of the patient's and, as appropriate, family members' involvement in the patient's treatment program. The patient record shall contain identifying data that is recorded on standardized forms. This identifying data shall include the following:

1. full name;
2. home address;
3. home telephone number;
4. date of birth;
5. sex;
6. race or ethnic origin;
7. next of kin;
8. education;
9. marital status;
10. type and place of employment;
11. date of initial contact or admission to the facility;
12. legal status, including relevant legal documents;
13. other identifying data as indicated;
14. date the information was gathered; and
15. signature of the staff member gathering the information.

111.21

The patient record shall contain information on any unusual occurrences such as the following:

1. treatment complications;
2. accidents or injuries to the patient;
3. morbidity;
4. death of a patient; and
5. procedures that place the patient at risk or that cause unusual pain.

111.22

As necessary, the patient record shall contain documentation of the consent of the patient, appropriate family members or guardians for admission, treatment, evaluation, aftercare, or research.

111.23

The patient record shall contain both physical and psychiatric diagnoses that have been made using a recognized diagnostic system.

111.24

The patient record shall contain reports of laboratory, roentgenographic, or other diagnostic procedures, and reports of medical/surgical services when performed.

111.25

The patient record shall contain correspondence concerning the patient's treatment, and signed and dated notations of telephone calls concerning the patient's treatment.

111.26

A discharge summary shall be entered in the patient's record within a reasonable period of time (not to exceed 14-days) following discharge as determined by the professional staff bylaws, rules and regulations.

111.27

The patient record shall contain a plan for aftercare.

111.28

All entries in the patient record shall be signed and dated. Symbols and abbreviations shall be used only if they have been approved by the professional staff, and only when there is an explanatory legend. Symbols and abbreviations shall not be used in the recording of diagnoses.

111.29

When a patient dies, a summation statement shall be entered in the record in the form of a discharge summary. The summation statement shall include the circumstances leading to death and shall be signed by a physician. An autopsy shall be performed whenever possible. When an autopsy is performed, a provisional anatomic diagnosis shall be recorded in the patient's record within 72 hours. The complete protocol shall be made part of the record within three months.

111.30 -- **Promptness of Record Completion**

111.31

Current records shall be completed promptly upon admission. Records of patients discharged shall be completed within 14 days following discharge. The staff regulations of the facility shall provide for the suspension or termination of staff privileges of physicians who are persistently delinquent

in completing records.

111.32 -- **Identification, Filing and Indexing**

111.33

A system of identification and filing to ensure the prompt location of a patient's medical record shall be maintained.

111.34

The patient index cards shall bear at least the full name of the patient, the address, the birth date, and the medical record number.

111.35

Records shall be indexed according to disease and physician and shall be kept up to date. For indexing, any recognized system may be used.

111.36

Indexing shall be current within six months following discharge of the patient.

Section L **-- Facility and Program Evaluation**

112.1

Program evaluation is a management tool primarily utilized by the facility's administration to assess and monitor, on a priority bases, a variety of facility, service, and programmatic activities.

112.2

The facility shall have a written statement of goals and objectives.

The goals and objectives shall result from a planning process.

The goals and objectives shall be related to the needs of the population served.

112.3

The written statement of the goals and objectives of the facility service and programmatic activities shall be provided to the governing body and facility administration and shall be made available to staff.

112.4

The facility shall have a written plan for evaluating its progress in attaining its goals and objectives.

112.5

The written plan shall specify the information to be collected and the methods to be used in retrieving and analyzing this information.

112.6

The written plan shall specify methods for assessing the utilization of staff and other resources to meet facility goals and objectives.

112.7

The written plan shall specify when evaluations shall be conducted.

112.8

The written plan shall specify the criteria to be used in assessing the facility's progress in attaining its goals and objectives.

112.9

The written plan shall require an explanation of any failure to achieve facility goals and objectives.

112.10

There shall be documentation that the goals and objectives of facility, service, and programmatic activities shall be evaluated at least annually and revised as necessary.

112.11

There shall be documentation that the results of the evaluation shall be provided to the governing body and facility administration and shall be made available to staff.

112.12

There shall be documentation that the findings of the evaluation have influenced facility and program planning.

Section M -- Fiscal Management

113.1

The facility shall annually prepare a formal, written budget of expected revenues and expenses.

113.2

The budget shall categorize revenues for the facility by source.

113.3

The budget shall categorize expenses by the types of services of programs provided.

113.4

The budget shall be reviewed and approved by the governing body prior to the beginning of the fiscal year.

113.5

Revisions made in the budget during the fiscal year shall be reviewed and approved by the governing body.

113.6

The fiscal management system shall include a fee schedule.

113.7

The facility shall maintain current, written schedules of rate and charge policies that have been approved by the governing body.

113.8

The fee schedule shall be accessible to personnel and to individuals served by the facility.

Section N -- Utilization Review

114.1

The facility shall demonstrate appropriate allocation of its resources by conducting a utilization review program. The program shall address underutilization, overutilization, and inefficient scheduling of the facility's resources.

114.2

The facility shall implement a written plan that describes the utilization review program and governs its operations.

114.3

The written plan shall include at least the following:

a. a delineation of the responsibilities and authority of those involved in utilization review activities, including members of the professional staff, the utilization review committees, the administration, and when applicable, any qualified outside organization contracted to perform review activities;
b. a conflict of interest policy applicable to everyone involved in utilization review activities;
c. a confidentiality policy applicable to all utilization review activities and to resultant findings and recommendations;
d. a description of the method(s) used to identify utilization-related problems;
e. the procedures for conducting concurrent review; and
f. a mechanism for initiating discharge planning.

114.4

The written plan shall be approved by the professional staff, the administration, and the governing body.

114.5

The methods for identifying utilization-related problems shall include analysis of the appropriateness and clinical necessity of admission, continued stays, and supportive services; analysis of delays in the provision of supportive services; and examination of the findings of related quality assurance activities and other current relevant documentation.

114.6

Such documentation may include, but is not limited to, profile analyses; the results of patient care evaluation studies, medication usage reviews, and infection control activities; and reimbursement agency utilization reports that are program/service-specific.

114.7

To identify problems and document the impact of corrective actions taken, retrospective monitoring of the facility's utilization of resources shall be ongoing.

114.8

The procedures for conducting concurrent review shall specify the time period following admission within which the review is to be initiated and the length-of-stay norms and percentiles to be used in assigning continued stay review dates.

114.9

Sources of payment shall not be the sole basis for determining which patients are to be reviewed concurrently.

114.10

Written measurable criteria and length-of-stay norms that have been approved by the professional staff shall be utilized in performing concurrent review and shall be included in, or appended to, the facility's utilization review plan.

114.11

Length-of-stay norms must be specific to diagnoses, problems, or procedures.

114.12

To facilitate discharge when care is no longer required, discharge planning shall be initiated as soon as the need for it can be determined.

114.13

Criteria for initiating discharge planning may be developed to identify those patients whose diagnoses, problems or psychosocial circumstances usually require discharge planning.

114.14

Discharge planning shall not be limited to placement in long term facilities, but shall also include provision for, or referral to, services that the patient may require to improve or maintain his or her mental health status.

114.15

The facility's utilization review program, including the written plan, criteria, and length-of-stay norms, shall be reviewed and evaluated at least annually and revised as necessary to reflect the findings of the program's activities.

114.16

A record shall be maintained or reviews of, and revisions to, the utilization review program.

114.17

The findings of such reviews shall be reported to the appropriate committee of the professional staff and to the governing body.

Part IV
Individualized Comprehensive Treatment Planning

Section A -- Intakes

201.1

Written policies and procedures governing the intake process shall specify the following:

a. the information to be obtained on all applicants or referrals for admission;
b. the records to be kept on all applicants;
c. the statistical data to be kept on the intake process; and
d. the procedures to be followed when an applicant or a referral is found ineligible for admission.

201.2

Criteria for determining the eligibility of children/adolescents for admission shall be clearly stated in writing.

201.3

The intake procedure shall include an initial assessment of the child/adolescent.

The intake assessment shall be done by a member of the professional staff. The results of the intake assessment shall be clearly explained to the patient (when appropriate) and to the patient's parents, legal guardian, or other authorized representative.

201.4

Acceptance of a child/adolescent for treatment shall be based on an intake procedure that meets the following conclusions:

a. the treatment required by the patient is appropriate to the intensity and restrictions of care provided by the facility or program component; and/or

b. the treatment required can be appropriately provided by the facility or program component; and
c. the alternatives for less intensive and restrictive treatment are not available.

201.5

During the intake process, every effort shall be made to assure that the child/adolescent and the parents, legal guardian, or other authorized adult understand the following:

a. the nature and goals of the treatment program;
b. the treatment costs to be borne by the family, if any; and
c. the rights and responsibilities of patients, including the rules governing patient conduct and the types of infractions that can result in disciplinary action or discharge from the facility or program component.

201.6

Facilities shall have policies and procedures that adequately address the following items for each patient:

a. responsibility for medical and dental care, including consents for medical or surgical care and treatment;
b. when appropriate, arrangements for family participation in the treatment program;
c. arrangements for clothing, allowances, and gifts;
d. arrangements regarding the patient's departure from the facility or program; and
e. arrangements regarding the patient's departure from the facility or program against clinical advice.

201.7

When a patient is admitted on court order, the rights and responsibilities of the patient and the patient's family shall be explained to them.

This explanation of the rights and responsibilities of the patient and the patient's family shall be documented in the patient's record.

201.8

Sufficient information shall be collected during the intake process to develop a preliminary treatment plan.

201.9

Staff members who will be working with the patient but who did not participate in the initial assessment shall be informed about the patient prior to meeting him or her.

Section B **-- Assessments**

202.1

Within 72 hours of admission, the staff shall conduct a complete assessment of each patient's needs. The assessment shall include, but shall not necessarily be limited to physical, emotional, behavioral, social, recreational, nutritional, and when appropriate, legal and vocational.

202.2

A licensed physician shall be responsible for assessing each patient's physical health. The health assessment shall include a medical history; a physical examination; and neurological examination when indicated and a laboratory workup. The physical examination shall be completed within 24 hours after admission.

202.3

In facilities serving children and adolescents, each patient's physical health assessment shall also include evaluations of the following: motor development and functioning; sensorimotor functioning; speech, hearing, and language functioning, visual functioning; and immunization status. Facilities serving children and adolescents shall have all necessary diagnostic tools and personnel available to perform physical health assessments.

202.4

A registered nurse shall be responsible for obtaining a nursing history and assessment at the time of admission.

202.5

A psychiatric evaluation of each patient shall be completed and entered into the patient's record. The evaluation shall include, but not be limited to, the following items:

a. a history of previous emotional, behavioral, and psychiatric problems and treatment;
b. the patient's current emotional and behavioral functioning;
c. when indicated, psychological assessments, including intellectual and personality testing.

When the admitting psychiatrist is not a qualified child psychiatrist, the psychiatric evaluation shall be reviewed by a qualified child psychiatrist who shall also directly evaluate the child/adolescent within seven days of admission to the psychiatric residential treatment facility.

202.6

A social assessment of each patient shall be completed by the qualified social worker and entered in the patient's record. The assessment shall include information relating to the following areas, as necessary:

a. environment and home
b. religion
c. childhood developmental history
d. financial status
e. the social, peer-group, and environmental setting from which the patient comes;
f. the patient's family circumstances, including the constellation of the family group, the current living situation, and social, ethnic, cultural, emotional, and health factors.

202.7

An educational assessment of each patient shall be completed by a qualified special education teacher and entered into the patient's record. The assessment shall include, but not be limited, to the following information:

a. Previous school history with regard to academic, social, and behavioral skills and deficits as well as school disciplinary actions; and
b. Psychometric measures as appropriate for the child/adolescent.

202.8

A recreational assessment of each patient shall be completed by the qualified recreational therapist and shall include information relating to the individual's current skills, talents, aptitudes, and interests.

202.9

A nutritional assessment shall be conducted by the food service supervisor or registered dietitian and shall be documented in the patient's record.

202.10

When appropriate, a vocational assessment of the patient shall be undertaken and shall include, but not be limited to, the following areas:

a. vocational history
b. educational history, including academic and vocational training, and
c. a preliminary discussion between the individual and the staff member doing the assessment concerning the individual's past experiences with, and attitudes toward work, present motivations or areas of interest, and possibilities for future education, training, and employment.

202.11

When appropriate, a legal assessment of the patient shall be undertaken and shall include, but not be limited to, the following areas:

a. a legal history; and
b. a preliminary discussion to determine the extent to which the individual's legal situation will influence his or her progress in treatment and the urgency of the legal situation.

Section C **-- Treatment Plans**

203.1

Each patient shall have a written individual treatment plan that is based on assessments of his or her clinical needs.

203.2

Overall development and implementation of the treatment plan shall be assigned to an appropriate member of the professional staff.

203.3

The treatment plan shall be developed within fourteen days of admission.

203.4

Appropriate therapeutic efforts may begin before a fully developed treatment plan is finalized.

203.5

Upon admission, a preliminary treatment plan shall be formulated on the basis of the intake assessment.

203.6

An initial interdisciplinary treatment plan shall be completed for each patient within 72 hours of admission to a psychiatric residential treatment facility. The initial treatment plan shall include:

a. Admission diagnosis or diagnostic impression;
b. A brief description or the patient's problems, strengths, conditions, disabilities, or needs;
c. Objectives relating to the patient's problems, conditions, disabilities and needs, and the treatments, therapies, and staff actions which will be implemented to accomplish these objectives;
d. Documentation of an attempt to contact the patient's school district or origin to participate in the treatment planning regarding the educational needs of the patient.

203.7

If a patient's stay in a facility is less than fourteen days only a discharge summary will be required in addition to the initial treatment plan.

203.8

If the patient's stay in a facility exceeds ten days the interdisciplinary team shall develop a comprehensive treatment plan within fourteen days of admission which shall be reviewed at least monthly for the first six months, and at least every ninety days thereafter.

The comprehensive treatment plan shall include:

a. Diagnosis;
b. A brief description of the patient's problems, strengths, conditions, disabilities, functional deficits or needs;
c. A brief description of the treatment and treatment planning which demonstrates that the program is addressing the functional deficits of the patient which substantiated the patient's eligibility for admission to the psychiatric residential treatment facility.
d. Goals to address the patient's problems, conditions, disabilities, and needs which indicate the expected duration of the patient's need for services in the psychiatric residential treatment facility;
e. Objectives relating to the patient's goals. Objectives must be written to reflect the expected progress of the patient. Interventions for accomplishing these objectives should be specific;
f. Specific treatments, therapies and staff interventions which will be implemented to accomplish each of the objectives and goals. These must be stated clearly to

enable all staff members participating in the treatment program to implement the goals and objectives;

g. If the facility utilizes a case management system, the name of the clinical staff member, designated as case coordinator, exercising primary responsibility for the patient;
h. Identification of the staff members who will provide the specified services, experiences and therapies;
i. Documentation of participation by the patient in the development of the treatment plan whenever possible and by the patient's parent or guardian and/or authorized adult, and by representatives of the patient's school district, where appropriate;
j. Date for the next scheduled review of the treatment plan;
k. Documentation that information obtained from the a patient's school district of origin, when available, was considered in developing or revising the comprehensive treatment plan.
l. A copy of an individual's education plan.

203.9

When appropriate, the patient and the patient's parents, legal guardian, or authorized adult shall participate in the development of his or her treatment plan, and such participation shall be documented in the patient's record.

Section D **-- Progress Notes**

204.1

Progress notes shall be recorded by the physician, nurse, social worker and, when appropriate, others significantly involved in treatment. The frequency of progress notes is determined by the condition of the patient but should be recorded at least monthly.

204.2

Progress notes shall be entered in the patient's record and shall include the following:

a. Documentation of implementation of the treatment plan;
b. Documentation of all treatment rendered to the patient;
c. Documentation of all progress in the patient's education program as determined in the patient's individual education plan;
d. Description of changes in the patient's condition;
e. Descriptions of the response of the patient to treatment, the outcome of treatment, and the response of significant others to important intercurrent events.

204.3

Progress notes shall be dated and signed by the individual making the entry.

204.4

All entries involving subjective interpretation of the patient's progress should be supplemented with a description of the actual behavior observed.

Section E **-- Treatment Plan Review**

205.1

Interdisciplinary case conferences shall be regularly conducted to review and evaluate each patient's treatment plan and his or her progress in attaining the stated treatment goals and objectives.

205.2

Interdisciplinary case conferences shall be documented, and the results of the review and evaluation shall be recorded in the patient's record. The review and update shall be completed no later than thirty (30) days following the first 14 days of treatment and at least monthly for the first six months and at least every 90 days thereafter.

Section F **-- Discharge Planning/Aftercare**

206.1

The facility maintains a centralized coordinated program to ensure that each patient has a planned program of continuing care which meets his post-discharge needs.

206.2

Each patient shall have an individualized discharge plan which reflects input from all disciplines involved in his care. The patient, patient's family, and/or significant others shall be involved in the discharge planning process.

206.3

An initial discharge plan shall be developed within 14 days of admission.

206.4

The chief executive officer shall delegate the responsibility for discharge planning, in writing, to one or more staff members (at least one of whom must be a qualified child psychiatrist).

206.5

The facility shall maintain written discharge planning policies and procedures which describe:

a. How the discharge coordinator will function, and his authority and relationships with the facility's staff;
b. The time period in which each patient's need for discharge planning is determined (within fourteen days of admission).
c. The maximum time period after which re-evaluation of each patient's discharge plan is made.
d. Local resources available to the facility and the patient to assist in developing and implementing individual discharge plan; and
e. Provisions for periodic review and re-evaluation of the facility's discharge planning program (At least annually).

206.6

An interdisciplinary case conference shall be held prior to the patient's discharge. Representatives from aftercare agencies including the anticipated school system will be encouraged to attend. The discharge/aftercare plan must be approved by a qualified child psychiatrist and shall be reviewed with the patient, patient's family and/or significant others.

206.7

The facility shall have documentation that the aftercare plan has been implemented and shall have documentation of follow-ups to assure referrals to appropriate community agencies.

Section G **-- Discharge Summary**

207.1

A discharge summary shall be entered in the patient's record within fourteen (14) days following discharge. The discharge summary shall include but not be limited to:

a. reason for admission
b. brief summary of treatment
c. reason for discharge
d. assessment of treatment plan goals and objectives
e. recommendations and arrangements for further treatment, including prescribed medications and aftercare.

Part V
Support Services

Section A -- Pharmacy

301.1 -- Direction and Supervision

301.2

A Facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each patient.

301.3

The facility must provide routine and emergency drugs and biological to its residents, or obtain them under an agreement part.

301.4

The facility must employ or obtain the services of a licensed pharmacists who:

a. Provides consultation on all aspects of the provision of pharmacy services in the facility;
b. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and
c. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
d. the pharmacist must submit a written report at least monthly to the CEO of the status of the performance of nursing personnel and any discrepancies noted in record keeping.

301.5 -- Control of Toxic or Dangerous Drugs

Policies shall be established to control the administration of toxic or dangerous drugs with specific reference to the duration of the order and the dosage. The facility shall establish a written policy

that all toxic or dangerous medications, not specifically prescribed as to time or number of doses, shall be automatically stopped after a reasonable time limit. The classification ordinarily thought of a toxic, dangerous or abuse drugs shall be narcotics, sedatives, anti-coagulants, antibiotics, oxytocics and cortisone products, and shall include other categories so established by federal, state or local laws.

301.6 -- **Labeling**

The facility must label drugs and biological in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date.

301.7

The facility shall have written policies and procedures designed to ensure that all medications are dispensed and administered safely and properly in accordance with the applicable federal, state, and local laws and regulations.

301.8

An up-to-date list of authorized prescribers shall be available in all areas where medication is dispensed.

301.9

Telephone orders shall be accepted only from individuals on the list of authorized prescribers.

301.10

Telephone orders shall be limited to situations that have been defined in writing in the facility's policies and procedures manual.

301.11

Telephone orders shall be accepted and written in the patient's record only by staff authorized to administer medication.

301.12

Telephone orders shall be signed by an authorized prescriber on the next regular working day, but in all events within 72 hours.

301.13

A written order signed by the authorized prescriber shall be included in patient's record.

301.14

Medication orders that contain abbreviations and chemical symbols shall be carried out only if the abbreviations and symbols are on a standard list approved by the physician members of the professional staff.

301.15

There shall be automatic stop orders on specified medications. Refer to 301.5.

301.16

There shall be a specific routine of drug administration, indicating dose schedules and standardization of abbreviations.

301.17

Only pharmacists, physicians, registered nurses, or licensed practical nurses shall administer medications.

301.18

Self administration of medication shall be permitted only when specifically ordered by the responsible physician.

301.19

Drugs brought into the facility by patients shall not be administered unless they can be absolutely identified, and unless written orders to administer these specific drugs are given by the responsible physician. If the drugs that the patient brings to the facility are not to be used,they shall be packaged, sealed, and stored, and, if approved by the responsible physician, they shall be returned to the patient, family, or significant others at the time of discharge.

301.20

The patient and, when appropriate, the family shall be instructed about which medications, if any,

are to be administered at home.

301.21

Medications administered, medication errors,a nd adverse drug reactions shall be documented in the patient's record.

301.22

Facilities should implement a reporting system under which the reporting program of the federal Food and Drug Administration and the drug manufacturer are advised of unexpected adverse drug reactions.

301.23

There shall be methods of detecting drug side effects or toxic reactions.

301.24

Investigational drugs shall be used only under the direct supervision of the principal investigator and with the approval of research review committee and either the physician members of the professional staff or an appropriate committee of the professional staff.

301.25 -- **Space for Storage of Drugs**

Adequate space shall be provided in the on premises Pharmacy for storage of drugs and for keeping of necessary records. The pharmacy shall be capable of being securely locked in accordance with regulations regarding storage of dangerous drugs. Adequate space is defined on a minimum of 350 square feet for 50 beds or less; 500 sq. ft. for 75 beds or less; 750 sq. ft. for 100 beds or less, and 1000 sq. ft. for 100 beds or more.

301.26

If there is no full-time pharmacists employed by the facility and if medications administered to patients are dispensed by pharmacist(s) elsewhere…then only the storage of pre-dispensed, individual medications (either medication containers or unit-dose medications) shall be allowed in the facility. The exception is for the allowance of Emergency Medications.

301.27

Storage of medications, as outlined directly above, in the facility shall be in an area to measure

not less than 100 square feet of space. This storage area is to be designated as the Medication Preparation Area/Room, and is to have the following personality:

a. Medication Refrigerator (for storage of drugs and biological);
b. Handwashing lavatory with hot water capability, and paper towel dispenser.
c. Medication Preparation Area/Room to have self-closing self-locking door(s);
d. The air temperature in the Medication Preparation Area/Room is not to exceed 85 degrees Fahrenheit or fall below 50 degrees Fahrenheit.
e. Medication Preparation Area/Room to have counter-top space provided for medication preparation.
f. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

301.28

All medication orders shall be reviewed monthly by the responsible physician. Adverse drug reactions and medication errors shall be reported to the physician responsible for the patient, and shall be documented in the patient's record.

301.29

The pharmacist in charge of dispensing medications shall provide for monthly inspection of all storage units including emergency boxes and emergency carts.

301.30

A record of these inspections shall be maintained in order to verify the following:

a. Disinfectants and drugs for external use are stored separately from internal and injectable medications.
b. Drugs requiring special conditions for storage to ensure stability are properly stored.

301.31

Adequate precautions shall be taken to store medications under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.

301.32

All drugs shall be kept in locked storage.

301.33

A central unit shall be established where essential information on investigational drugs,such as dosage form, dosage range, storage requirements, adverse reactions, usage, and contraindications, is maintained.

301.34

Investigational drugs shall be properly labeled.

301.35

Nurses may administer investigational drugs only after receiving basic pharmacologic information about the drugs.

301.36

The facility shall have specific methods for controlling and accounting for drug products.

301.37

The pharmacy service shall maintain records of its transactions as required by law and as necessary to maintain adequate control of, and accountability for, all drugs.These records shall document all supplies issued to units, departments, or services of the facility, as well as prescription drugs dispensed.

301.38

Records and inventories of the drugs listed in the current Comprehensive Drug Abuse Prevention and Control Act shall be maintained as required by the act and regulations.

301.39

Distribution and administration of controlled drugs are adequately documented, and inspections of these records by the pharmacist is documented.

301.40

There is an emergency kit that is:

a. made up under the supervision of responsibility of the pharmacist, and approved by the Clinical Director;
b. readily available to staff yet not accessible to patients;
c. constituted so as to be appropriate to the needs of the patients; and
d. inspected monthly to remove deteriorated and outdated drugs and to ensure completeness of content.

301.41

The pharmacist responsible for the emergency kit shall provide a list of its contents and appropriate instructions, and shall authenticate this list with his signature.

301.42

Poisons, external drugs, and internal drugs shall be stored on separate shelves or in separate cabinets.

301.43

Medications that are stored in a refrigerator containing items other than drugs shall be kept in a separate compartment or container with proper security.

301.44

Antidote charts and the telephone number of the Regional Poison Control Center shall be kept in all drug storage and preparation areas.

301.45

Up-to-date pharmaceutical reference material shall be provided so that appropriate staff will have adequate information concerning drugs.

301.46

Current editions of text and reference books covering the following topics shall be provided; theoretical and practical pharmacy; general, organic, pharmaceutical, and biological chemistry; toxicology; pharmacology; bacteriology; sterilization and disinfection; and other subjects important to good patient care.

Section B -- Dietary

302.1 -- **Organization**

302.2

The facility shall have an organized dietary department directed by a qualified food service supervisor, with services of a registered dietitian on at least a consultant basis. However, a facility which has a contract with an outside food management company may be found to meet this requirement if the company has a therapeutic dietitian who serves, as required by scope and complexity of the services, on a full-time, part-time, or consultant basis to the facility. If the dietitian is not employed full-time a certified food service supervisor should direct the dietary department.

302.3

The qualified dietitian shall be registered or eligible for registration by the Commission on Dietetic Registration.

302.4

When a qualified dietitian is employed on a part-time or consultative basis, the dietitian shall devote enough time to accomplish the following tasks:

1. assure continuity of services;
2. direct the nutritional aspects of patient care;
3. assure that dietetic instructions are carried out;
4. on occasion, supervise the serving of meals; and assist in the evaluation of the dietetic services.

302.5

Regular written reports shall be submitted to the chief executive officer on the extent of services provided by the dietitian

302.6

There shall be written policies and procedures for food storage, preparation, and service developed by a registered dietitian.

302.7

The dietetic service shall have an adequate number of appropriately qualified individuals to meet the dietetic needs of the facility's patients. Dietetic service personnel shall assist patients when necessary in making appropriate food choices from the planned daily menu. Dietetic services personnel shall be made aware that emotional factors may cause patients to change their food habits. Dietetic service personnel shall inform appropriate members of the professional staff of any change in a patient's food habits.

302.8

Written job descriptions of all dietary employees shall be available.

302.9

The shall be procedures to control dietary employees with infectious and open lesions. Routine health examinations shall meet local and state codes for food service personnel.

302.10

There shall be an on-going planned inservice training program for dietary employees which includes the proper handling of food and personal grooming, safety, sanitation, behavioral and therapeutic needs of patients.

302.11 -- **Facilities**

302.12

Adequate space, equipment, ventilation and supplies as well as any necessary written procedure and precautions, shall be provided for the safe and sanitary operation of the dietetic service and the safe and sanitary handling and distribution of food.

302.13

The food service area should be appropriately located.

302.14

The dietitian's office should be easily accessible to all who require consultation services.

302.15

Sufficient space shall be provided for support personnel to perform their duties.

302.16

The layout of the department and the type, amount, size, and placement of equipment shall make possible the efficient and sanitary preparation and distribution of food.

302.17

Lavatories with wrist action blades, soap dispenser and disposable towel dispenser shall be located throughout the dietary department.

302.18

Dry or staple food items shall be stored in a ventilation room which is not subject to sewage or waste water backflow, or contamination by condensation, leakage, rodents or vermin.

302.19

All perishable foods shall be refrigerated at the appropriate temperature and in an orderly and sanitary manner. Each refrigerator shall contain a thermometer in good working order.

302.20

Foods being displayed or transported shall be protected from contamination.

302.21

Dishwashing procedures and techniques shall be developed and carried out in compliance with the state and local health codes.

302.22

All garbage and kitchen refuse which is not disposed of mechanically shall be kept in leakproof non-absorbent containers with close fitting covers and be disposed of routinely in a manner that will not permit transmission of disease, a nuisance, or a breeding place for flies.

302.23

All garbage containers are to be thoroughly cleaned inside and outside each time emptied.

302.24

All dietary areas, equipment, walls, floors, etc., shall be kept maintained in good working condition and sanitary at all times.

302.25 -- **Diets**

302.26

There shall be a systematic record of diets, correlated when appropriate, with the medical records. The dietitian shall have available an up-to-date manual of regimens for all therapeutic diets, approved jointly by the dietitian and medical staff, which is available to dietary supervisory personnel. Diets served to patients shall be in compliance with these established diet principles:

a. The diet manual shall be reviewed annually and revised as necessary by a qualified dietitian, and shall be dated to identify the time of the review.
b. Revisions to the diet manual shall be approved by the facility's physician.
c. The diet manual should be used to standardize the ordering of diets.
d. The policies and procedures shall provide for dietetic counseling.
e. The nutritional deficiencies of any diet in the manual shall be indicated.
f. The policies and procedures shall require the recording of dietetic orders in the patient's record.
g. The policies and procedures shall require the recording of all observations and information pertinent to dietetic treatment in the patient's record by the food service supervisor or dietitian.
h. The policies and procedures shall require the use of standards for nutritional care in evaluating the nutritional adequacy of the patient's diet and in ordering diet supplements. The current Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences is suggested as a guide in developing these standards.
i. The policies and procedures shall describe the methods for assuring that each patient on a special diet received the prescribed diet regimen.
j. The policies and procedures shall provide for altering diets or diet schedules as well as for discontinuing diets.
k. Dietetic service personnel shall conduct periodic food acceptance studies among the patients and should encourage them to participate in menu planning.
l. The results of food acceptance studies should be reflected in revised menus.

m. All menus shall be approved by a qualified dietitian.

302.27 -- **Food Service and Dining**

302.28

Food shall be served in an appetizing and attractive manner, at planned and realistic mealtimes, and in a congenial and relaxed atmosphere.

302.29

Dining areas should be attractive and maintained at appropriate temperatures.

302.30

The dietetic services shall be patient-oriented and should take into account the many factors that contribute to the wide variations in patient eating habits, including cultural, religious, and ethnic factors.

302.31

Snacks shall be available as appropriate to the nutritional needs of the patient and the needs of the facility.

302.32

The dietetic service shall be prepared to give extra food to individual patients.

302.33

Appropriate food should be available for patients with special or limited dietary needs.

302.34

There shall be adequate equipment provided for tray assembly and tray delivery.

302.35

Facilities or arrangements shall be available for family and friends to eat with patients when possible.

Section C -- Recreation

303.1

The facility shall provide or make arrangements for the provision of recreation services to all patients in accordance with their needs and interests and as appropriate within the scope of the facility's program.

303.2

The facility shall have a written plan that describes the organization of their recreation services or the arrangements made for the provision of recreation services. The recreation services shall have a well-organized plan for using community resources. The goals and objectives of the facility's recreation services shall be stated in writing.

303.3

The facility shall have written policies and procedures for the recreation services which are made available to recreation services and other appropriate personnel. The policies and procedures shall be reviewed and revised at least annually.

303.4

Recreational activities shall be provided to all patients during the day, in the evening, and on weekends. The daily recreation program shall be planned to provide a consistent and well-structured yet flexible framework for daily living. Whenever possible, patients should participate in planning recreational services.

303.5

Recreation schedules shall be posted in places accessible to patients and staff.

303.6

The recreation program shall be reviewed and revised according to the changing needs of the patients.

303.7

When indicated, recreation services shall be incorporated in the patient's treatment plan.

Recreation services that are included in a patient's treatment plan shall reflect an assessment of the patient's needs, interests, life experiences, capacities, and deficiencies. Recreation services staff shall collaborate with other professional staff in delineating goals for patient's treatment, health maintenance, and vocational adjustments.

303.8

The patient's record shall contain progress notes that describe the patient's response to recreation services and other pertinent observations.

303.9

There shall be documentation that patients are given leisure time and that they are encouraged to use their leisure time in a way that fulfills their cultural and recreational interests and their feelings of human dignity.

303.10

Vehicles used for transportation shall not be labeled in a manner that calls unnecessary attention to the patient.

303.11 -- **Quality Assurance Activities**

303.12

The recreation services shall have written procedures for ongoing review and revision of its goals, objectives, and role within the facility.

303.13

The recreation service shall maintain statistical and other records on the functioning and utilization of the services.

303.14 -- **Continuing Education**

303.15

The facility service shall maintain ongoing staff development programs. Recreation service staff shall participate in appropriate clinical and administrative committees and conferences. Recreation services staff shall receive training and demonstrate competence in handling medical and psychiatric emergencies. The recreation service shall encourage extramural studies and evaluations

of recreation services and extramural research in recreation services.

303.16 -- **Functional Safety and Sanitation**

303.17

Appropriate space, equipment, and facilities shall be provided to meet the needs of patients for recreation services.

a. Facilities and equipment designated for recreation services shall be constructed or modified in such a manner as to provide, insofar as possible, pleasant and functional areas that are accessible to all patients regardless of their disabilities.
b. Space for offices,storage, and supplies shall be adequate and accessible.
c. When indicated, equipment and supplies that enable the activity to be brought to the patient should be used.
d. Space, equipment and facilities utilized both inside and outside the facility shall meet federal, state, and local requirements for safety, fire prevention, health, and sanitation.

Section D **-- Physical and Occupational Therapy**

304.1

The facility shall provide, or arrange for, under written agreement, physical and occupational therapy services as needed by patients to improve and maintain functioning.

304.2

Qualified therapists, consultants, volunteers, assistants, or aides, are sufficient in number to provide comprehensive occupation and physical therapy services, as needed, to assure that appropriate treatment is rendered for each patient in accordance with stated goals and objectives.

304.3

Services are provided only upon the written order of a licensed physician.

304.4

The therapist must:

a. Record regularly and evaluate periodically the treatment training progress.
b. Use the treatment training progress as the basis for continuation or change in the

program.

304.5

Treatment training programs shall be designed to:

a. Preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and activities of daily living.
b. Prevent, insofar as possible, irreducible disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adoptions, and sensory stimulation.

304.6

Evaluation results, treatment objectives, plans and procedures and progress notes shall be recorded in the patient's record.

304.7

For effective and efficient physical and occupational therapy services,the facility shall provide sufficient space, equipment and supplies.

304.8

Physical and occupational therapists shall meet the qualifications of 106.31.

304.9

Therapy assistants must work under the supervision of the qualified therapist.

Section E **-- Education**

305.1

The facility shall provide, or make arrangements for the provision of, education services to meet the needs of all patients.

305.2

Special education services shall be provided for patients whose emotional disturbances make it

difficult for them to learn.

305.3

Education services shall provide opportunities for patients who have fallen behind because of their disorder, to correct deficiencies in their education.

305.4

Facilities that operate their own education service shall have adequate staff and space to meet the educational needs of patients. These facilities shall adhere to all regulations and standards of the State Department of Education that would assure receipt of approval for all work successfully completed within each individual's education plan and transferable to other educational providers, e.g. local public school districts in the State, following the patient's discharge.

305.5

An education director and staff who meet state and/or local certification requirements for education and/or special education shall be provided.

305.6

Special education teachers shall be certified for the Emotionally Handicapped.

305.7

An appropriate ratio of teachers to students shall be provided so teachers can give special attention to students or to groups of students who are at different stages of treatment and education.

305.8

The education service shall have space and materials commensurate with the scope of its activities, including an adequate number of classrooms.

305.9

When indicated, patients shall participate in education programs in the community. Teachers in the community shall be given the information necessary to work effectively with the patient.

305.10

Clinicians shall periodically confer with teachers or principals on the progress of each patient.

305.11

When appropriate, patients shall be encouraged to take part in extra curricular school activities.

305.12

There shall be documentation in each patient's record of periodic evaluations of educational achievement in relation to developmental level, chronological age, sex, special handicaps, medications, and psychotherapeutic needs.

Section F **-- Vocational Rehabilitation**

306.1 -- **Policies and Procedures**

306.2

Patients shall receive counseling on their specific vocational needs, for example, a vocational strengths and weaknesses, the demands of their current or future job, the responsibilities of holding a job, and the problems related to vocational training, placement, and employment.

306.3

A facility may delegate vocational rehabilitation responsibilities to an outside vocational rehabilitation agency. However, the agency must assign an individual approved by the facility to serve as the facility's coordinator of vocational rehabilitation and agree to comply with the standards in this section.

306.4

Facilities that have a vocational rehabilitation service shall have written policies and procedures to govern the operation of the service.

306.5

The vocational rehabilitation service shall assess the patients vocational needs with regard to the

following:

a. current work skills and potential for improving skills or developing new ones;
b. educational background;
c. aptitudes, interests, and motivations for getting involved in various job-related activities;
d. physical abilities;
e. skills and experiences in seeking jobs;
f. work habits related to tardiness, absenteeism, dependability, honesty, and relations with co-workers and supervisor;
g. personal grooming and appearance;
h. expectations regarding the personal, financial, and social benefits to be derived from working; and
i. amenability to vocational counseling.

306.6

Vocational services shall be provided according to an individualized treatment plan.

306.7

The criteria for determining a patient's job readiness shall be stated in the patient's treatment plan.

306.8

A record shall be kept of vocational rehabilitation activities, including the date and a description of the activity, participants, and results.

306.9

All work programs must conform to federal, state, and local rules and regulations.

306.10 -- **Staff Composition and Supervision**

306.11

The facility's vocational rehabilitation service shall have a sufficient number of appropriately qualified staff and support personnel thru direct or contractual services.

306.12

A person or team shall be assigned responsibility for the implementation of vocational rehabilitation services.

306.13

Vocational Rehabilitative Services shall be provided by at least one qualified vocational rehabilitation counselor or qualified occupational therapist available who is responsible for the professional standards, coordination, and delivery of vocational rehabilitation services.

306.14

All personnel providing vocational rehabilitation services shall have training, experience, and competence consistent with acceptable standards of their specialty field.

306.15

Sufficient qualified vocational rehabilitation counselors and support personnel shall be available to meet the needs of patients.

Section G **-- Speech, Language, and Hearing**

307.1 -- **Policies and Procedures**

307.2

Speech, language, and hearing services shall be available, either within the facility or by written arrangement with another facility or a qualified clinician, to provide assessments of speech, language, or hearing when indicated, and to provide counseling, treatment, and rehabilitation when needed.

307.3

Facilities that have a speech, language, and hearing service shall have written policies and procedures to govern the operation of the service.

307.4

The speech, language, and hearing service shall provide the following services:

a. speech and language screening of patients when deemed necessary by members of

the treatment team, the family, or significant others;

b. comprehensive speech and language evaluation of patients when indicated by screening results;
c. comprehensive audiological assessment of patients when indicated;
d. procurement, maintenance, or replacement of hearing aids when specified by a qualified audiologist; and
e. rehabilitation programs, when appropriate, to establish the speech skills necessary for comprehension and expression.

307.5

Assessment and treatment results shall be reported accurately and systematically and in a manner that accomplishes the following:

a. defines the problem;
b. provides a basis for formulating a plan that contains treatment objectives and procedures;
c. provides information of staff working with the patient; and
d. provides evaluations and summary reports for inclusion in the patient's record.

307.6 -- **Staff Composition and Supervision**

307.7

The speech, language, and hearing service shall be administered and supervised by qualified speech-language and hearing clinicians.

307.8

All staff with independent responsibilities shall have a Certificate of Clinical Competence or a Statement of Equivalence in either speech pathology or audiology from the American Speech-Language-Hearing Association, or have documented equivalent training and experience; and shall meet current legal requirements of licensure or registration.

307.9

Support personnel, such as speech pathology assistants and communication aides, shall be qualified by training and/or experience for level of work they perform and shall be appropriately supervised by a staff speech-language pathologist or audiologist.

307.10 -- **Quality Assurance Activities**

307.11

Equipment shall meet the standards of the American Board of Examiners in Speech Pathology and Audiology of the American Speech-Language-Hearing Association, including the standards concerning the location, calibration, and maintenance of equipment; or equipment shall meet equivalent standards.

Section H **-- Dental**

308.1 -- **Policies and Procedures**

308.2

The facility shall have a written plan that outlines the procedures used to assess and treat the dental health care needs of patients.

308.3

The written dental health care plan shall describe the following:

a. mechanisms for evaluating each patient's need for dental treatment;
b. provisions for emergency dental services;
c. policies on oral hygiene and preventive dentistry;
d. provisions for coordinating dental services with other services provided by the facility; and
e. a mechanism for the referral of patients for services not provided by the facility.

308.4

When a facility provides dental services, a written policy shall delineate the functions of the service and the specific services provided.

308.5

Reports of all dental services provided shall be made a part of the patient's record.

308.6 -- **Staff Composition and Supervision**

308.7

A dental service provided by the facility shall be directed by a fully licensed dentist who is a member of the professional staff and qualified to assume management and administrative responsibility for the dental service.

308.8

A dental service provided by the facility shall have a sufficient number of adequately trained personnel to meet the needs of patients.

308.9 -- **Functional Safety and Sanitation**

308.10

A dental service provided by the facility shall have adequate space, equipment, instruments, and supplies to meet the needs of patients.

Section I **-- Referrals**

309.1

The facility shall have written policies and procedures that facilitate the referral of patients and the provision of consultation between the facility's program components and between the facility and other service providers in the community. The written policies and procedures shall describe the conditions under which referrals can be made and consultations provided. These conditions shall provide for the examinations, assessments, or consultations that are not within the professional domain or expertise of the staff; special treatment services; and assistance from providers who can contribute to the patient's well-being.

309.2

The written policies and procedures shall describe the methods by which continuity of care is assured for the patient. These methods shall include, but not be limited to, providing the facility, program component, or other service provider to which the patient is referred with the following:

a. background information on the referral;
b. information on the patient's treatment, for example, current treatment, diagnostic assessments, and special requirements;
c. treatment objectives desired;
d. suggestions for continued coordination between the referring and the receiving resource;
e. special clinical management requirements; and;
f. information on how the patient can be returned to the referring facility or program component.

309.3

The facility shall ask the facility, program component, or other service provider to which the patient is referred to submit a follow-up report within a designated time period.

309.4

The written policies and procedures shall describe the mechanism by which a patient may request a referral.

309.5

The written policies and procedures shall describe the means by which the facility assists in the referral of individuals who are seeking services that the facility does not provide.

309.6

The written policies and procedures shall be reviewed and approved annually by the director and appropriate administrative and professional staff members. The annual review and approval shall be documented.

309.7

Each community service provider to which patients are referred shall express in writing its willingness to abide by federal and state standards concerning confidentiality of patient information.

309.8

The facility shall have a letter of agreement and/or contract with community service providers that it uses repeatedly.

Section J **-- Emergency**

310.1

The facility shall have written procedures for taking care of emergencies. Emergency services shall be provided by the facility or through clearly defined arrangements with another facility.

310.2

When emergency services are provided by an outside facility, a written plan shall delineate the type of emergency services available and the arrangements for referring or transferring patients to another facility. The written plan shall be available to all professional staff and shall clearly specify the following:

a. The staff of the facility who are available and authorized to provide necessary emergency evaluations;
b. The staff of the facility who are authorized to arrange for patients to be referred or transferred to another facility when necessary;
c. The arrangements the facility had made for exchanging records with the outside facility when it is necessary for the care of the patient;
d. The location of the outside facility and the names of the appropriate personnel to contact;
e. The method of communication between the two facilities;
f. The arrangements the facility has made to assure that when a patient requiring emergency care is transferred to a nonpsychiatric or substance abuse service or facility, he or she will receive further evaluation and/or treatment of his or her psychiatric or substance abuse problem, as needed;
g. The arrangements the facility has made for transporting patients, when necessary, from the facility to the facility providing emergency services;
h. The policy for referring patients needing continued care after emergency services back to the referring facility; and
i. Policies concerning notification of patient's family of emergencies and of arrangements that have been made for referring or transferring the patient to another facility.

Section K **-- Library**

311.1

Library services shall be made available to meet the professional and technical needs of the facility's staff.

311.2

Facilities that do not maintain a professional library shall have an arrangement with a nearby facility or institution to use its professional library.

311.3

Current reference material, books, and basic health care journals shall be available in each facility.

311.4

The library shall establish regular and convenient hours of service so that staff may have prompt access to current materials.

311.5

When a facility operates its own library, the professional library service shall provide pertinent, current and useful medical, psychiatric, psychological, alcohol, drug, educational, and related materials.

311.6

A facility providing extensive library services should utilize the services of a professional librarian.

Section L **-- Laboratory/Radiology**

312.1

The facility shall have provisions for promptly obtaining required laboratory, x-ray, and other diagnostic services.

312.2

If the facility provides its own laboratory and x-ray services, these shall meet the applicable standards established for hospital licensure. Refer to Part III, Chapter 6, Section 627, 628 and Part VI, Chapters 19 and 21 of the Minimum Standards of Operation for Mississippi Hospitals.

312.3

If the facility itself does not provide such services, arrangements shall be made for obtaining these services from a licensed and certified laboratory.

312.4

All laboratory and x-ray services shall be provided only on the orders of the attending physician.

312.5

The facility shall assist the patient, if necessary, in arranging for transportation to and from the source of service.

312.6

All signed and dated reports of laboratory, x-ray, and other diagnostic services shall be filed with the patient's medical record.

Section M **-- Volunteer**

313.1

In facilities where volunteer services are utilized, the objectives and scope of the volunteer service shall be clearly stated in writing.

313.2

An appropriately qualified and experienced staff member shall be assigned to select and evaluate volunteers and to coordinate volunteer activities.

313.3

The authority and responsibilities of the volunteer coordinator shall be clearly stated in writing.

313.4

The volunteer coordinator shall perform the following functions:

a. assist staff in determining the need for volunteer services and in developing assignments;
b. plan and implement the program for recruiting volunteers;
c. coordinate efforts to recruit, select, and train volunteers, and to place volunteers in appropriate services or units;

d. instruct staff on the proper, effective, and creative use of volunteers;
e. keep staff and the community informed about volunteer services and activities;
f. provide opportunities for volunteers to acquire the qualifications for certification when applicable; and
g. assign an appropriate staff member to provide ongoing supervision, inservice training, and evaluation of volunteers.

313.5

An orientation program shall be conducted to familiarize volunteers with the facility's goals and services and to provide appropriate clinical orientation regarding the facility's patients.

313.6

The orientation program shall include explanations of at least the following:

a. the importance of maintaining confidentiality and protecting patients' rights;
b. the procedures for responding to unusual events and incidents; and
c. the program's channels of communication and the distinctions between administrative and clinical authority and responsibility.

313.7

Volunteers shall be under the direct supervision of the staff of the service or unit utilizing their services, and shall receive general direction and guidance form the volunteer coordinator.

313.8

The use of volunteers as members of treatment teams to supplement the total treatment program shall be done only in collaboration with appropriate professional staff members and after consideration of the patients' needs for continuity.

313.9

Supervisory professional staff shall be available to help volunteers establish the most effective relationship with patients.

313.10

Procedures shall be established to assure that the observations of volunteers are reported to the professional staff members responsible for the patient. These observations may be recorded in the

patient's record.

313.11

Volunteers may be utilized to help meet patients' basic needs for social interaction, self-esteem, and self-fulfillment.

313.12

Volunteer activity records and reports shall contain information that can be used to evaluate the effectiveness of the volunteer services.

313.13

At least the following records shall be maintained by the volunteer service:

a. a personnel record that includes the volunteer's application, record of assignments, and progress reports;
b. a master assignment schedule for all volunteers, including times and units of assignment; and
c. a current job description for each volunteer.

Section L **-- Research (optional)**

314.1

When a facility or program conducts or participates in research with human subjects, policies shall be designed and written to assure that rigorous review is made of the merits of each research project and of the potential effects of the research procedures on the participants.

314.2

An interdisciplinary research review committee shall review all research projects utilizing human subjects. The committee shall be either a permanent standing committee or a committee convened on an as-needed basis.

314.3

Members of the research review committee shall be qualified by training and experience to serve on the committee.

314.4

Individuals who have appropriate experience in the research areas being reviewed shall be included on the committee.

314.5

A majority of the committee members should be individuals who are not directly associated with the research project under consideration.

314.6

Some committee members should be individuals who are not formally associated with the facility.

314.7

Prior to the authorization and initiation of each research project, the research committee shall conduct a detailed review of the project.

314.8

This review shall include the following:

a. the adequacy of the research design;
b. the qualifications of the individuals responsible for coordinating the project;
c. the benefits of the research in general;
d. the benefits and risks to the participants;
e. the benefits to the facility;
f. the compliance of the research design with accepted ethical standards;
g. the process to be used to obtain informed consent from participants; and
h. the procedures for dealing with any potentially harmful effects that may occur in the course of the research activities.

314.9

This initial review shall form the basis for a written report that shall be submitted by the committee to the chief executive officer.

314.10

All individuals asked to participate in a research project shall be given the following information before being asked to give their consent:

a. a description of the benefits to be expected;
b. a description of the potential discomforts and risks;
c. a description of alternative services that might prove equally advantageous to them; and
d. a full explanation of the procedures to be followed, especially those that are experimental in nature.

314.11

If the investigator does not wish to fully disclose the purpose, nature, expected outcome, and implications of the research to the participants before it begins, the investigator shall clearly and rigorously justify to the research review committee that such disclosure is inadvisable and that failure to give full disclosure is not detrimental to the participants. Under such conditions, disclosure may be deferred until the research project is completed.

314.12

All research project participants shall sign a consent form that indicates their willingness to participate in the project.

314.13

All consent forms, except as provided in Standard 314.11 shall address all of the information specified in Standard 314.10 and shall indicate the name of the person who supplied the participant with the information and the date the form was signed.

314.14

The informed consent document shall address the participant's right to privacy and confidentiality.

314.15

Neither the consent form nor any written or oral agreement entered into by the participant shall include any language that releases the facility, its agents, or those responsible for conducting the research from liability for negligence.

314.16

All prospective participants over the age of 12 and all parents or guardians of participants under the age of 18 shall sign a written consent form that indicates willingness to participate in the project.

314.17

The consent form shall address all of the information specified in 314.10 and shall indicate the name of the individual who supplied the participant with the information and the date the consent form was signed.

314.18

Prospective participants under the age of 18, and all prospective participants who are legally or functionally incompetent to provide informed consent,shall participate only when and if consent has been given by a person legally empowered to consent, and such consent has been reviewed by an independent advocacy group, if available.

314.19

Such legal guardian and/or advocate shall receive the same information as required in Standard 314.10 and shall sign the consent form.

314.20

A patient's refusal to participate in a research project shall not be a cause for denying or altering the provision of indicated services to that patient.

314.21

Participants shall be allowed to withdraw consent and discontinue participation in a research project at any time without affecting their status in the program.

314.22

Privacy and confidentiality should be strictly maintained at all times.

314.23

Upon completion of the research procedures, the principal investigator shall attempt to remove any confusion, misinformation, stress, physical discomfort, or other harmful consequences that may have arisen with respect to the participants as a result of the procedures.

314.24

Investigators and others directly involved in research shall, both in obtaining consent and in conducting research, adhere to the ethical standards of their respective professions concerning the conduct of research and should be guided by the regulations of the US Department of Health and Human Services and other federal, state, and local statues and regulations concerning the protection of human subjects.

314.25

Upon completion of the research, the principle investigator, whether a member of the facility's staff or an outside researcher, shall be responsible for communicating the purpose, nature, outcome, and possible practical or theoretical implications of the research to the staff of the program in a manner which they can understand.

314.26

Reports of all research projects shall be submitted to the chief executive officer and the research committee and shall be maintained by the facility.

Part VI
Physical Plant Management

Section A -- Infection Control

401.1

Because infections, acquired in a facility or brought into a facility from the community, are potential hazards for all persons having contact with the facility, there shall be an infection control program. Effective measures shall be developed to prevent, identify, and control infections.

401.2

Written policies and procedures pertaining to the operation of the infection control program shall be established, reviewed at least annually, and revised as necessary.

401.3

A practical system shall be developed for reporting, evaluating, and maintaining records of infections among patients and personnel. This system shall include assignment of responsibility for the ongoing collection and analysis of data, as well as for the implementation of required follow-up action. Corrective action taken on the basis of records and reports of infections and infection potentials among patients and personnel shall be documented.

401.4

All new employees shall be instructed in the importance of infection control and personal hygiene, and in their responsibility in the infection control program. There shall be documentation that inservice education in infection prevention and control is provided to employees in all services and program components.

Section B -- Medical Waste

402.1

"Infectious medical wastes" include solid or liquid wastes which may contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host has been

proven to result in an infectious disease. For purposes of this Regulation, the following wastes shall be considered to be infectious medical wastes:

(1) Wastes resulting from the care of patients and animals who have Class I and (or) II diseases that are transmitted by blood and body fluid as defined in the rules and regulations governing reportable diseases, as defined by the Mississippi State Department of Health;

(2) Cultures and stocks of infectious agents; including specimen cultures collected from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biological, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures;

(3) Blood and blood products such as serum, plasma, and other blood components;

(4) Pathological wastes, such as tissues, organs, body parts, and body fluids that are removed during surgery and autopsy;

(5) Contaminated carcasses, body parts, and bedding of animals that were exposed to pathogens in medical research;

(6) All discarded sharps (e.g., hypodermic needles, syringes, Pasteur pipettes, broken glass, scalpel blades) which have come into contact with infectious agents;

(7) Other wastes determined infectious by the generator or so classified by the State Department of Health.

"Medical Waste" means all waste generated in direct patient care or in diagnostic or research areas that is non-infectious but aesthetically repugnant if found in the environment."

402.2

All generators of infectious medical waste and medical waste shall have a medical waste management plan that shall include, but is not limited to, the following:

402.3

Storage and Containment of Infectious Medical Waste and Medical Waste:

A. Containment of infectious medical waste and medical waste shall be in a manner and location which affords protection from animals, rain and wind, does not provide a breeding place or a food source for insects and rodents, and minimizes exposure to the public.

B. Infectious medical waste shall be segregated from other waste at the point of origin in the producing facility.

C. Unless approved by the Mississippi State Department of Health or treated and rendered non-infectious, infectious medical waste (except for sharps in approved containers) shall not be stored at a waste producing facility for more than seven days above a temperature of 6 c (38F). Containment of infectious medical waste at the producing facility is permitted at or below a temperature of 0 C/32F) for a period of not more than 90 days without specific approval of the Department of Health.

D. Containment of infectious medical waste shall be separate from other wastes. Enclosures or containers used for containment of infectious medical waste shall be so secured so as to discourage access by unauthorized persons and shall be marked with prominent warning signs on, or adjacent to, the exterior of entry doors, gates, or lids. Each container shall be prominently labeled with a sign using language to be determined by the Department and legible during daylight hours.

E. Infectious medical waste, except for sharps capable of puncturing or cutting, shall be contained in double disposable plastic bags or single bags (1.5 mills thick) which are impervious to moisture and have a strength sufficient to preclude ripping, tearing, or bursting under normal conditions of usage. The bags shall be securely tied so as to prevent leakage or expulsion of solid or liquid wasted during storage, handling, or transport.

F. All bags used for containment and disposal of infectious medical waste shall be of a distinctive color or display the Universal Symbol for infectious waste. Rigid containers of all sharps waste shall be labeled.

G. Compactors or grinders shall not be used to process infectious medical waste unless the waste has been rendered non-infectious. Sharps containers shall not be subject to compaction by any compacting device except in the institution itself and shall not be placed for storage or transport in a portable or mobile trash compactor.

H. Infectious medical waste and medical waste contained in disposable containers as prescribed above, shall be placed for storage, handling, or transport in disposable or reusable pails, cartons, drums, or portable bins. The containment system shall be leakproof, have tight-fitting covers and be kept clean and in good repair.

I. Reusable containers for infectious medical waste and medical waste shall be thoroughly washed and decontaminated each time they are emptied by a method specified by the Mississippi State Department of Health, unless the surfaces of the containers have been protected from contamination by disposable liners, bags, or

other devices removed with the waste, as outlined in I.E.

Approved methods of decontamination include, but are not limited to, agitation to remove visible soil combined with one or more of the following procedures:

1. Exposure to hot water at least 180 F for a minimum of 15 seconds.

2. Exposure to a chemical sanitizer by rinsing with or immersion in one of the following for a minimum of 3 minutes:

    a. Hypochlorite solution (500 ppm available chlorine).
    b. Phenolic solution (500 ppm active agent).
    c. Iodoform solution (100 ppm available iodine).
    d. Quaternary ammonium solution (400 ppm active agent).

Reusable pails, drums, or bins used for containment of infectious waste shall not be used for containment of waste to be disposed of as non-infectious waste or for other purposed except after being decontaminated by procedures as described in part (J) of this section.

J. Trash chutes shall not be used to transfer infectious medical waste.

K. Once treated and rendered non-infectious, previously defined infectious medical waste will be classified as medical waste and may be landfilled in an approved landfill.

402.4

Treatment or disposal of infectious medical waste shall be by one of the following methods:

A. By incineration in an approved incinerator which provides combustion of the waste to carbonized or mineralized ash.

B. By sterilization by heating in a steam sterilizer, so as to render the non-infectious. Infectious medical waste so rendered non-infectious shall be disposable as medical waste. Operating procedures for steam sterilizers shall include,but not be limited to, the following:

1. Adoption of standard written operating procedures for each steam sterilizer including time, temperature, pressure, type of waste, type of container(s), closure on container(s), pattern of loading, water

content, and maximum load quantity.

2. Check or recording and/or indicating thermometers during each complete cycle to ensure the attainment of a temperature of 121 C (250 F) for one-half hour or longer, depending on quantity and density of the load, in order to achieve sterilization of the entire load. Thermometers shall be checked for calibration at least annually.
3. Use of heat sensitive tape or other device for each container that is processed to indicate the attainment of adequate sterilization conditions.
4. Use of the biological indicator Bacillus stearothermophilus placed at the center of a load processed under standard operating conditions at least monthly to confirm the attainment of adequate sterilization conditions.
5. Maintenance of records of procedures specified in (1), (2), (3) and (4) above for period of not less than a year.

C. By discharge to the approved sewerage system if the waste is liquid or semi-liquid, except as prohibited by the State Department of Health.

D. Recognizable human anatomical remains shall be disposed of by incineration or internment, unless burial at an approved landfill is specifically authorized by the Mississippi State Department of Health.

E. Chemical sterilization shall use only those chemical sterilants recognized by the U. S. Environmental Protection Agency, Office of Pesticides and Toxic Substances. Ethylene oxide, glutaraldehyde, and hydrogen peroxide are examples of sterilants that, used in accordance with manufacturer recommendation, will render infectious waste non-infectious. Testing with Bacillus subtilis spores or other equivalent organisms shall be conducted quarterly to ensure the sterilization effectiveness of gas or steam treatment.

402.5

Treatment and disposal of medical waste which is not infectious shall be by one of the following methods:

A. By incineration in an approved incinerator which provides combustion of the waste to carbonized or mineralized ash.

B. By sanitary landfill, in an approved landfill which shall mean a disposal facility or part of a facility where medical waste is placed in or on land, and which is not a treatment facility.

All the requirements of these standards shall apply, without regard to the quantity of medical waste generated per month, to any generator of medical waste.

Section C -- Therapeutic Environment

403.1

The facility shall establish an environment that enhances the positive self-image of patients and preserves their human dignity.

403.2

The grounds of the facility shall have adequate space for the facility to carry out its stated goals.

403.3

When patient needs or facility goals involve outdoor activities, areas appropriate to the ages and clinical needs of the patients shall be provided.

403.4

The facility shall be accessible to handicapped individuals, or the facility shall have written policies and procedures that describe how handicapped individuals can gain access to the facility for necessary services.

403.5

Waiting or reception areas shall be comfortable; and their design, location, and furnishings shall accommodate the characteristics of patient and visitors, the anticipated waiting time, the need for privacy and/or support form staff, and the goals of the facility.

403.6

Appropriate staff shall be available in waiting or reception areas to address the needs of patients and visitors.

403.7

Rest rooms shall be available for patients and visitors.

403.8

A telephone shall be available for private conversations.

403.9

An adequate number of drinking units shall be accessible at appropriate heights.

403.10

If drinking units employ cups, only single-use, disposable cups shall be used.

403.11

Facilities that do not have emergency medical care resources shall have first-aid supply kits available in appropriate places.

403.12

All supervisory staff shall be familiar with the locations, contents, and use of the first-aid kits.

403.13

The facility shall provide an environment appropriate to the needs of patients.

403.14

The design, structure, furnishing, and lighting of the patient environment shall promote clear perceptions of people and functions.

403.15

When appropriate, lighting shall be controlled by patients.

403.16

Whenever possible the environment shall provide views of the outdoors.

403.17

Areas that are primarily used by patients shall have windows or skylights.

403.18

Appropriate types of mirrors that distort as little as possible shall be placed at reasonable heights in appropriate places to aid in grooming and to enhance patients' self-awareness.

403.19

Clocks and calendars should be provided in at least major use areas to promote awareness of time and season.

403.20

Ventilation shall contribute to the habitability of the environment.

403.21

Direct outside air ventilation shall be provided to each patient's room by air conditioning or operable windows.

403.22

Ventilation shall be sufficient to remove undesirable odors.

403.23

All areas and surfaces shall be free of undesirable odors.

403.24

Door locks and other structural restraints should be used minimally.

403.25

The use of door locks or closed sections shall be approved by the professional staff and the governing body.

403.26

The facility shall have written policies and procedures to facilitate staff-patient interaction, particularly when structural barriers in the therapeutic environment separate staff from patients.

403.27

Staff should respect a patient's right to privacy by knocking on the door of the patient's room before entering.

403.28

Areas with the following characteristics shall be available to meet the needs of patients:

a. Areas that accommodate a full range of social activities, from two-person conversations to group activities;
b. Attractively furnished areas in which a patient can be alone, when appropriate; and
c. Attractively furnished areas for private conversations with other occupants, family or friends.

403.29

Appropriate furnishings and equipment shall be available.

403.30

Furnishings shall be clean and in good repair.

403.31

Furnishings shall be appropriate to the age and physical conditions of the patients.

403.32

All furnishings, equipment, and appliances shall be maintained in good operating order.

403.33

Broken furnishings and equipment shall be repaired promptly.

403.34

Dining areas shall be comfortable, attractive, and conducive to pleasant living.

403.35

Dining arrangements shall be based on a logical plan that meets the needs of the patients and the requirements of the facility.

403.36

Dining tables should seat small groups of patients, unless other arrangements are justified on the basis of patient needs.

403.37

When staff members do not eat with the patients, the dining rooms shall be adequately supervised and staffed to provide assistance to patients when needed and to assure that each patient received an adequate amount and variety of food.

403.38

Sleeping areas shall have doors for privacy.

403.39

In rooms containing more than four patients, privacy should be provided by partitioning or placement of furniture.

403.40

The number of patients in a room shall be appropriate to the ages, developmental levels, and clinical needs of the patients and to the goals of the facility.

403.41

Except when clinically justified in writing on the basis of program requirements, no more than eight patients shall-sleep in a room.

403.42

Sleeping areas shall be assigned on the basis of the patient's need for group support, privacy, or independence.

403.43

Patients who need extra sleep, whose sleep is easily disturbed, or who need greater privacy because of adjustment problems shall have single or double bedrooms.

403.44

Areas shall be provided for personal hygiene.

403.45

The areas for personal hygiene shall provide privacy.

403.46

Bathrooms and toilets shall have partitions and doors.

403.47

Toilets shall have seats.

403.48

Good standards of personal hygiene and grooming shall be taught and maintained, particularly in regard to bathing, brushing teeth, caring for hair and nails, and using the toilet.

403.49

Patients shall have the personal help needed to perform these activities and, when indicated, to assume responsibility for self-care.

403.50

The services of a barber and beautician shall be available to patients either within the facility on

in the community.

403.51

Articles for grooming and personal hygiene that are appropriate to the patient's age, developmental level, and clinical status shall be readily available in a space reserved near the patient's sleeping area.

403.52

If clinically indicated, a patient's personal articles may be kept under lock and key by staff.

403.53

Ample closet and drawer space shall be provided for storing personal property and property provided for patient's use.

403.54

Lockable storage space should be provided.

403.55

Patients shall be allowed to keep and display personal belongings and to add personal touches to the decoration of their rooms.

403.56

The facility should have written rules to govern the appropriateness of such decorative display.

403.57

If access to potentially dangerous grooming aides or other personal articles is contraindicated for clinical reasons, the professional staff shall explain to the patient the conditions under which the articles may be used and shall document the clinical rationale for these conditions under which the articles may be used and shall document the clinical rationale for these conditions in the patient's record.

403.58

If the hanging of pictures on walls and similar activities are privileges to be earned for treatment

purposes, the professional staff shall explain to the patient the conditions under which the privileges may be granted and shall document the treatment and granting of privileges in the patient's record.

403.59

Patients shall be encouraged to take responsibility for maintaining their own living quarters and for other day-to-day housekeeping activities of the program, as appropriate to their clinical status.

403.60

Such responsibilities shall be clearly defined in writing, and staff assistance and equipment shall be provided as needed.

403.61

Descriptions of such responsibilities shall be included in the patients' orientation program.

403.62

Documentation shall be provided that these responsibilities have been incorporated into the patient's treatment plan.

403.63

Patients shall be allowed to wear their own clothing.

403.64

If clothing is provided by the program, it shall be appropriate and shall not be dehumanizing.

403.65

Training and help in the selection and proper care of clothing shall be available as appropriate.

403.66

Clothing shall be suited to the climate.

403.67

Clothing shall be becoming, in good repair, of proper size, and similar to the clothing worn by the patient's peers in the community.

403.68

An adequate amount of clothing shall be available to permit laundering, cleaning, and repair.

403.69

A laundry room should be accessible so patients may wash their clothing.

403.70

The use and location of noise-producing equipment and appliances, such as television, radios, and record players, shall not interfere with other therapeutic activities.

403.71

A place and equipment shall be provided for table games and individual hobbies.

403.72

Toys, equipment, and games shall be stored on shelves that are accessible to patients as appropriate.

403.73

Books, magazines, and arts and crafts materials shall be available in accordance with patients' recreational, cultural, and educational backgrounds and needs.

403.74

Each facility shall formulate its own policy regarding the availability and care of pets and other animals, consistent with the goals of the facility and with the requirements of good health and sanitation.

403.75

Depending on the size of the program, facilities shall be available for serving snacks and preparing meals for special occasions and recreational activities, for example, baking cookies or making popcorn or candy. These facilities shall permit patient participation.

403.76

Unless contraindicated for therapeutic reasons, the facility shall accommodate the patients' need to be outdoors through the sue of nearby parks and playgrounds, adjacent countryside, and facility grounds.

403.77

Recreational facilities and equipment shall be available, consistent with the patients' needs and the therapeutic program.

403.78

Recreational equipment shall be maintained in working order.

403.79

The environment shall be maintained and equipped so as to ensure the health and safety of the patients. Physical health and safety features of the environment shall conform to requirements of local, state, and federal authorities having jurisdiction. In any event, the facility shall provide verification of the following:

a. patients shall be protected against the danger of fire and smoke.
b. patients shall be protected against injury attributable to the design and equipment of the environment.
c. patients shall be protected against electrical hazard.
d. patients shall be protected against spread of disease and infection.

403.80

Fire Control and Internal Disaster. The facility shall provide fire protection by the elimination of fire hazards the installation of necessary safeguards such as extinguisher, sprinkling devices, fire barriers to insure rapid and effective fire control and the adoption of written fire control and evacuation plans rehearsed at least three times a year by key personnel.

403.81

Written fire control plans shall contain provisions for prompt reporting of all fires extinguishing fires; protection of patients, personnel and guests evacuation; training of personnel in sue of first aid fire fighting equipment' and cooperation with fire fighting authorities.

403.82

The facility shall have:

A. Written evidence of regular inspection and approval by state or local fire control agencies.
B. Stairwells kept closed by fire doors and equipped with unimpaired automatic closing devices.
C. Fire extinguisher refilled when necessary and kept in condition for instant use. There shall be an annual inspection of each fire extinguisher which shall include a tag showing the month and year of the inspection and the initials of the inspector. Each liquid type extinguisher shall be hydrostatically tested every five years.
D. Proper routine storage and prompt disposal of trash.
E. "No Smoking" signs prominently displayed where appropriate, with rules governing the ban on smoking in designated areas enforced and obeyed by all personnel.
F. Fire regulations easily available to all personnel and all fire codes rigidly observed and carried out.
G. Corridors and exits clear of all obstructions except for permanently mounted handrails.

Section D **-- Physical Plant Construction**

404.1

General. Every institution subject to these Minimum Standards shall be housed in a safe building which contains all the facilities required to render the services contemplated in the application for license.

404.2

Codes. The term "safe" as used in Section 404 hereof shall be interpreted in the light of compliance with the requirements of the latest codes presently in effect, which are incorporated by reference as a part of these Minimum Standards; National Fire Codes which includes the Life Safety Code, National Fire Protection Association or Standard Building Code, Southern Building Code Congress and Standard Plumbing Code, Southern Building Code Congress or American Standard National Plumbing Code, American Standards Association No. 17.3; and Sanitary Code of the Mississippi State Department of Health.

404.3

New buildings must conform to the codes listed in the paragraph above. Where a choice of codes is provided above, applicant may chose which of the codes he will follow, and the provisions of the code chosen shall apply throughout except to the extent that these Minimum Standards specifically permit deviation therefrom.

404.4 -- **Submission of Plans and Specifications**

404.5

Construction shall not be started for any institution subject to these standards (whether new or remodeling or additions to an existing facility) until the plans and specifications for such construction or remodeling have been submitted to the Licensing Agency in writing and its approval of the changes given in writing.

Exception. Foundation changes made necessary by unanticipated conditions, or any conditions which present a hazard to life or property if not immediately corrected.

404.6

Plans and specifications for any substantial construction or remodeling should be prepared by competent architects and engineers licensed to practice in the state and who assume responsibility for supervising the construction. The following plans shall be submitted to the Licensing Agency for review:

A. Preliminary Plans - To include schematics of building, plot plans showing size and shape of entire site, existing structures, if any, streets and location and characteristics of all needed utilities, floor plans of every floor diminished and with proposed use of each room or area shown. If for additions or remodeling, plan of existing building showing all proposed alterations, outline specifications to include a general description of the construction, type of finishes, and type of heating, ventilating, plumbing and electrical systems proposed.

B. Final Working Drawings and Specifications - Complete and in sufficient detail to be the basis for the award of construction contracts.

404.7

All plans submitted for review must be accompanied in their first submission by an order of the governing board indicating the type and scope of license to be applied for.

404.8

Plans receiving approval of the Licensing Agency upon which construction has not begun within six (6) months following such approval must be resubmitted for approval.

404.9

In all new facilities, plans must be submitted to all regulatory agencies, such as the County Health Department, etc., for approval prior to starting construction.

404.10

Upon completion of construction an inspection shall be made by the Licensing Agency and approval given prior to occupying the building or any part thereof.

404.11

Environment. All facilities shall be so located that they are reasonably free from undue noises, smoke,dust or foul odors, and should not be located adjacent to railroads, freight yards, schools, children's playgrounds, airports, industrial plants or disposal plants.

404.12

Zoning Restrictions. The locations of an institution shall comply with all local zoning ordinances.

404.13

Access. Institutions located in rural areas must be served by good roads which can be kept passable at all times.

404.14

Elements of Construction. Corridors-shall be 6'0" wide and 7'6" high (clear). The surface of all floors and walls shall be washable. All corridors longer than 150' shall be subdivided by a smoke barrier and must be maintained free of obstruction.

404.15

Doors. All doors in corridors shall be 20-minutes fire rated floors (1-3/4" solid core wood door as a minimum). All doors to patient bedrooms, diagnostic and treatment areas, and other doors

used by residents shall be at least 36" wide. No door shall swing into the corridor except closet doors. Doors to hazardous areas defined in the Life Safety Code shall be 1-1/2 hours "B" labeled fire doors. Exit doors shall conform to the requirements set forth in the Life Safety Code.

404.16

Stairs. Shall be 44" wife, minimum; be in a 2-hour fire enclosure; and have a "B" (1-1/2 hour) level door at all landings.

404.17

Elevators. One power driven elevator is required in all facilities having patient rooms above the first floor. Two or more elevators are required if 60 or more patients are housed above the ground floor.

404.18

One-Story Building. Wall, ceiling and roof construction shall be of a type approved as being of 1-hour fire resistive construction as defined by National Bureau of Fire Underwriters or the Bureau of Standards. Floor systems shall be of non-combustible construction.

404.19

Multi-Story Buildings. Must be of two-hour fire resistive constructions as defined in Standard Building Code or comply with the Life Safety Code of National Fire Protection Association as applied to hospitals.

404.20

Fire Reporting and Protection. A manually operated electrically supervised fire alarm system shall be installed in each facility. There must be a telephone in the building to summon help in case of fire.

404.21

Sprinkler systems tied into the fire alarm system shall be provided at least for hazardous areas. Adequate water supply shall be provided for the sprinkler system. Hazardous areas are: Laundries, Storage Areas, Repair and Maintenance Shops,Soiled Linen Collection Rooms, Trash Collection Rooms, Laundry Chutes, and Trash Chutes.

404.22

Flame Spread Rate (ASTM Standard E84-61) on all wall and ceiling surfaces in required exists and hazardous areas shall be 25 or less. All other areas shall have a flame spread rating of not more than 75, except that up to 10% of the aggregate wall and ceiling area may have a finish with a rating up to 200.

404.23

Heating and Ventilating. Suitable artificial heat shall be furnished to maintain 75 degrees F, inside temperature with 10 degrees F, outside temperature. Circulating hot water from a remote boiler or vapor-steam with circulating pumps and controls on emergency electrical service to provide heating in case of power failures are the preferred methods of heating. Electrical heating will be approved provided a standby electric generator is provided of capacity to furnish 80% of the maximum heating load in addition to other power and lighting loads that may be connected to it, or the facility is supplied by two electric service lines connected to separate transformers at the sub-station so arranged that electric services can be maintained in case of failure of one line or transformer. Direct fired units are forbidden except in areas such as laundries, storerooms, kitchens, and similar occupancies and then only if in ductwork or more than 8 feet above the floor. Open flame heaters are prohibited. Gas fired ranges and other appliances (except Bunsen burners) may be used where no hazard is created,but must be services with rigid pipe connections. Gas fired sterilizer, water heater, and other like appliances shall have provided adequate air intake for combustion and full venting for combustion products. No hall will be used as a plenum. Mechanical ventilation shall be installed in all toilets and janitors closets.

404.24

Toilets, janitors closets, soiled linen, dishwashing and similar areas shall have six (6) air changes per hour. Areas occupied by patients shall have tow (2) air changes per hour.

404.25

Plumbing. All institutions subject to these standards shall be connected to an approved municipal water system or to a private supply whose purity has been certified by the laboratory of the State Department of Health. Private supplies must be sampled, tested, and its purity certified at least twice annually and immediately following any repair or modification to the underground lines, the elevated tank, or to the well or pump. Supply must be adequate, both as to volume and pressure, for fire fighting purposes. Deficiencies in either must be remedied by the provision of auxiliary pumps, pressure tanks or elevated tanks as may be required.

404.26

An approved circulating method of supplying hot water for all uses must be provided. Water to lavatories and bathing areas must be 100 degrees-110 degrees F. Water to mechanical

dishwashers must be delivered at 180 degrees F. for rinsing.

404.27

Supply piping within the building shall be in accordance with plumbing code incorporated by reference in Section 404.25 hereof. Special care must be taken to avoid use of any device or installation which might cause contamination of the supply through back-siphonage or cross connections.

404.28

Sewage Disposal. All institutions subject to these standards shall dispose of all sanitary wastes through connection to a suitable municipal sewerage system or through a private sewerage system that has been approved in writing by the Sanitary Engineering Department of the State Department of Health and the Air and Water Pollution Board.

404.29

All fixtures located in the kitchen, including the dishwasher, shall be installed so as to empty into a drain which is not directly connected to the sanitary house drain. Kitchen drain may empty into a manhole or catch basin having a perforated cover with an elevation of at least 24" below the kitchen floor elevation, and thence to the sewer. Exceptions; existing licensed institutions which have no plumbing fixtures installed on floors which are above the floor on which the kitchen is located.

404.30 -- **Emergency Electric Service.**

General. To provide electricity during an interruption of the normal electric supply that could affect the medical care, treatment, or safety of the occupants, an emergency source of electricity shall be provided and connected to certain circuits for lighting and power. The source of this emergency electric service shall be an emergency generator, with a stand-by supply of fuel of 24 hours. Emergency electrical systems shall be provided in accordance with the applicable section of the Life Safety Code.

404.31

Patient Rooms. Each patient room shall meet the following requirements:

a. Shall contain 100 sq. ft. of floor area for a single bedroom and 80 sq. ft. per bed in multi-bedrooms.
b. Ceiling Height. Shall be 8'0" minimum.
c. All rooms housing patients shall be outside rooms and shall have window area equal to 1/8 of the floor area. The sill shall not be higher than 36 inches above the

floor and shall be above grade. Windows shall not have any obstruction to vision (wall, cooling tower, etc.) within 50 feet as measured perpendicular to the plane of the window.

d. Each patient shall be provided with a hanging storage space of not less than 16" X 24" X 52" for his personal belongings.
e. Each patient room shall be equipped with a quality bed acceptable for his environment.
f. A bedside cabinet or table shall be provided.
g. Rooms shall be equipped with curtains or blinds at windows. All curtains shall have a flame spread of 25 or less.
h. All walls shall be suitable for washing.
i. All walls and ceilings shall have a 1-hour fire rating.
j. A lavatory shall be located in the bedroom or in a private toilet room.
k. Patient bed light shall be provided which shall be capable of control by the patient.
l. Night light shall be provided which is bright enough for the nurse to do her duties, but dim enough not to disturb the patient.

404.32

Service Areas. The size of each service area will depend on the number beds within the unit and shall include the following:

A. Nurses Station. For charting, communication and storage for supplies and nurses personal effects.
B. Nurses Toilet with Lavatory. Convenient to nurses station.
C. Clean Work Room. For storage and assembly of supplies. Shall contain storage cabinets or storage carts, work counter and sink.
D. Soiled Utility. Shall contain deep sink work counter, waste receptacle, soiled linen receptacle.
E. Medicine Station. Adjacent to nurses station, with sink, small refrigerator, locked storage and work counter. (May be in clean work room in self-contained cabinet.)
F. Clean Linen Storage. A closet large enough to hold an adequate supply of clean linen.
G. Provision for between-meal nourishments.
H. Patient Bath. At least one tub or shower stall for each 18 patients not served by private bath.
I. Fire Extinguisher. One approved Class 2A unit for each 3000 sq/ ft.
J. Janitor's Closet. Closet large enough to contain floor receptor with plumbing and space for some supplies and mop buckets.

404.33

Special Care Room for Isolation. It shall contain:

A. One patient bed per room.
B. Private lavatory and toilet.

404.34

Seclusion Room. If a seclusion room is provided, it shall be provided with a key-only lock or an electronic lock on the door and a security screen on the window.

404.35

Dietary. Construction and equipment shall comply with State Department of Health regulations, and shall include:

A. Food preparation center. Provide lavatory (without mirror) with wrist action blades, soap dispenser and disposable towel dispenser. All cooking appliances to have ventilating hood.
B. Food serving facilities. If dining space is provided, it shall contain a minimum of 15 sq. ft. per person seated.
C. Dishwashing room. Provide commercial type dishwashing equipment.
D. Pot washing facilities.
E. Refrigerated storage (three day supply).
F. Day storage (three day supply.)
G. Cart cleaning facilities (can be in dishwashing room.)
H. Can wash and storage (must be fly-tight).
I. Cart storage.
J. Dietitian's office.
K. Janitors closet.
L. Personnel toilets and lockers convenient to, but not in, the kitchen proper.
M. Approved automatic fire extinguisher system in range hood. In addition, Class 1B extinguisher to be installed in the kitchen.

404.36

Administrative Area. To include:

A. Business office with information desk, and personnel toilets.
B. Administrator's office.
C. Admitting area.
D. Lobby or foyer, with public toilets.
E. Medical Library (This area should be as close to medical records as possible).
F. Space for conferences and in-service training.
G. Medical records--office and storage.
H. Director of Nurses' office.

I. Fire Extinguisher. An approved Class 2A unit shall be provided.

404.37

Housekeeping Area. To include:

A. Housekeepers's office or suitable area designated for record keeping.
B. Storage space for maid's carts, if used.

Laundry. To include:

A. Soiled linen room with lavatory with wrist action blades.
B. Clean linen and mending area. (To include space for storage of clean linen carts).
C. Laundry process room. Commercial type equipment sufficient for the needs of the facility. (If laundry is processed outside facility, this area not needed.)
D. Janitors closet
E. Facilities shall be provided for personal laundry for use by patients. This area shall be separated from areas by a one hour fire rated wall.

404.38

General Storage. There shall be a two hour fire rated lockable room large enough to provide five square feet of general storage for each bed provided. If storage is provided in a separate building it must be fifty feet away.

404.39

Boiler Room. Space shall be adequate for the installation and maintenance of the required machinery.

404.40

Maintenance Area. Sufficient area for performing routine maintenance activities shall be provided and shall include an office or suitable area designated for recordkeeping.

404.41

Day Room. At least two general areas for use as living room, day room or recreation shall be provided. A minimum of 18 square feet per patient bed shall be available for this purpose.

404.42

Dining Room. A minimum of 15 square feet per patient bed shall be provided for use as a Dining Room. Adequate tables and chairs shall be provided to seat all patients, staff and guests.

404.43

Counseling Rooms. At least one small room shall be provided for each 20 patients for the purpose of individual private treatment or counseling.

404.44

Examination and Treatment Room. At least one room shall be provided for the purpose of examination and treatment. The room shall be equipped with a lavatory and towel dispenser, examination table and storage space, with adequate lighting.

404.45

Group Counseling Rooms. At least two rooms shall be provided large enough to accommodate 8-10 patients for the purpose of group counseling sessions.

Part VII
Glossary

Administrative. Relates to the fiscal and general management of a facility rather than to the direct provision of services to patients.

Aftercare. Services that are provided to a patient after discharge and that support and increase the gains made during treatment.

Applicant. An individual who has applied for admission to a program but who has not completed the intake process.

Approved. Acceptable to the authority having jurisdiction.

Assessment. Those procedures by which a program evaluates an individual's strengths, weakness, problems and needs.

Audiological Assessment. The audiological tests for delineating the site of auditory dysfunction, including such tests as pure tone air-conduction and bone-conduction threshold, speech reception thresholds, speech discrimination measurements, impedance measurements, and others.

Audiologists, Qualified. An individual who is certified by the American Speech-Language-Hearing Association as clinically competent in the area of audiology and is licensed by the State.

Audiometric Screening. A process that may include such tests as pure tone aid conduction thresholds, pure tone air-conduction thresholds, pure tone air-conduction suprathreshold screenings, impedance measurements, or observations of reactions to auditory stimuli.

Audit, Financial. An independent review by a public accountant certifying that a facility's financial reports reflect its financial status.

Authentication. Proof of authority and responsibility by written signature, identifiable initials, computer key, or other method. The use of a rubber stamp signature is acceptable only under the following conditions: the person whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it, and this person gives the chief executive officer a signed statement that he or she is the only one who has the stamp and is the only one who will use it.

Authority Having Jurisdiction. The organization, office, or individual responsible for

approving a piece of equipment, an installation, or a procedure.

Bylaws. The laws, rules, or regulations adopted for the government of the facility. Also used for the laws, rules, or regulations of the professional staff.

Chief Executive Officer. A job-descriptive term used to identify the individual appointed by the governing body to act on its behalf in the overall management of the facility. Other job titles may include administrator, superintendent, director, president, vice-president, and executive vice-president.

Child Psychiatrist, Qualified. A doctor of medicine who specializes in the assessment and treatment of children and/or adolescents having psychiatric disorders and who is fully licensed to practice medicine in the state in which he or she practices. The individual shall have successfully completed training in a child psychiatry fellowship program approved by the Liaison Committee on Graduate Medical Education of the American Medical Association of have been certified in child psychiatry by the American Board of Psychiatry and Neurology.

Child Psychologist, Qualified. An individual licensed by the State Board of Psychological Examiners with a specialty area in either developmental psychology or in clinical or counseling psychology with demonstrated educational background and experience in the evaluation and treatment of children and/or adolescents.

Department. A staff entity organized on administrative, functional, or disciplinary lines.

Dietetic Services. The provision of services to meet the nutritional needs of patients, with specific emphasis on patients who have special dietary needs, for example, patients who are allergic to certain foods or who cannot accept a regular diet.

Diet Manual. An up-to-date, organized system for standardizing the ordering of diets.

Discharge. The point at which the patient's active involvement with a facility is terminated and the facility no longer maintains active responsibility for the patient.

Drug History. A delineation of the drugs used by a patient, including prescribed and unprescribed drugs and alcohol. A drug history includes, but is not necessarily limited to, the following: drugs used in the past; drugs used recently, especially within the preceding 48 hours; drugs of preference; frequency with which each drug is used; route of administration of each drug; drugs used in combination; dosages used; year of first use of each drug; previous occurrences of overdose, withdrawal, or adverse drug reactions; and history or previous treatment received for alcohol or drug abuse.

Emergency Kit. A kit designed to provide the medical supplies and pharmaceutical agents required during an emergency. In compiling emergency kits, staff should consider the patients'

needs for psychotropic, anticholinergic, and adrenalin agents.

External Disaster. A catastrophe that occurs outside the facility and for which the facility, based on its size, and resources must be prepared to serve the community.

Facility. An organization that provides psychiatric substance abuse, and/or mental health services to patients.

Fiscal Management. Procedures used to control a facility's overall financial and general operations. Such procedures may include cost accounting, program budgeting, materials purchasing, and patient billing.

Formulary. A catalog of the pharmaceuticals approved for use in a facility. A formulary lists the names of the drugs and information regarding dosage, contraindications, and unit dispensing size.

Goal. An expected result or condition that takes time to achieve, that is specified in a statement of relatively broad scope, and that provides guidance in establishing intermediate objectives directed towards its attainment.

Governing Body. The person or person with ultimate authority and responsibility for the overall operation of the facility.

Guardian. A parent, trustee, committee, conservator, or other person or agency empowered by law to act on behalf of, or have responsibility for, an applicant or patient.

Hazardous Area. Any area in which the following are used: products that are highly combustible, highly flammable, or explosive; or materials that are likely to burn with extreme rapidity or produce poisonous fumes or gases. Consult the 1972 edition of the Life Safety Code (NFPA 101) for further clarification.

Hazardous Procedures. Procedures that place the patient at physical or psychological risk or in pain.

Human Subject Research. The use of patients receiving services in the systematic study, observation, or evaluation of factors related to the prevention, assessment, treatment and understanding of an illness. This involves all behavioral and medical experimental research that involves human beings and experimental subjects.

Incident Reports. Documentation of events or actions that are likely to lead to adverse effects and/or that vary from established policies and procedures pertaining to patient care.

Intake. The administrative and assessment process for admission to a program.

Interdisciplinary Team. A group of clinical staff composed of representative from different

professions, disciplines, or service areas.

Listed. Used to indicate equipment or materials included in a list published by a nationally recognized testing laboratory, inspection agency, or other organization concerned with product evaluation. The organization periodically inspects the production of listed equipment or materials, and the organization's list states that the equipment or material either meets nationally recognized standards or has been tested and found suitable for use in a specified manner.

May. Used to reflect an acceptable method of compliance with a standard that is recognized but not preferred. See shall and should.

Medical Record Administrator, Qualified. A registered record administrator who has successfully passed an appropriate examination conducted by the American Medical Record Association.

Medical Record Technician, Qualified. An accredited record technician who has successfully passed the appropriate accreditation examination conducted by the American Medical Record Association.

NFPA. National Fire Protection Association, 470 Atlantic Avenue, Boston, Massachusetts 02210.

Nurse. A person licensed and registered to practice nursing in the state in which he or she practices.

Nurse, Practical. A person licensed or registered as a practical or vocational nurse in the state in which he or she practices.

Nurse, Psychiatric, Qualified. A licensed nurse who has had at least two years of experience in psychiatric or mental health nursing and at least one year of experience in a supervisory position.

Objective. An unexpected result or condition that takes less time to achieve than a goal, is stated in measurable terms, has a specified time for achievement, and is related to the attainment of a goal.

Occupational Therapist, Qualified. An individual who is a graduate of an occupational therapy program approved by a nationally recognized accrediting body, or who currently holds certification by the American Occupational Therapy Association as an occupational therapist, registered, who meets any current legal requirements of licensure or registration; and who is currently competent in the field.

Outreach. The process of systematically interacting with the community to identify persons in need of services, alert persons and their families to the availability of services, locate needed

services, and enable persons to enter the service delivery system.

Parenteral Product. Sterile, pharmaceutical preparations ingested by the body through a route other than the alimentary canal.

Patient. An individual who receives treatment services. Patient is synonymous with client, resident, consumer, and recipient of treatment services.

Personnel Record. The complete employment record of a staff member or an employee, including job application, education and employment history, performance evaluation, and, when applicable, evidence of current licensure, certification, or registration.

Pharmacist, Qualified. An individual who has a degree in pharmacy and is licensed and registered to prepare, preserve, compound, and dispense drugs and chemicals in the state in which he or she practices.

Physical Therapist. A graduate of a physical therapy program approved by a nationally recognized accrediting body, or shall hold current registration and is currently competent in the field.

Physician, Qualified. A doctor of medicine or doctor of osteopathy who is fully licensed to practice medicine in the state in which he or she practices.

Program. A general term for an organized system of services designed to address the treatment needs of patients.

Program Evaluation. An assessment component of a facility that determines the degree to which a program is meeting its stated goals and objectives.

Recreation Therapist, Qualified. An individual who is a qualified recreation specialist; or has a bachelors' degree in recreation and one year of recreational experience in a health care setting; or has an associate degree in recreation or in a specialty area such as art or music plus completion of comprehensive inservice training in recreation.

Recreation Services. Structured activities designed to develop an individual's creative, physical, and social skills through participation in recreational, art, dance, drama, social, and other activities.

Rehabilitation Counselor. An individual who has a bachelor's degree in rehabilitation counseling and three years of experience in working with children/adolescents.

Restraint. A physical or mechanical device used to restrict the movement of the whole or a portion of a patient's body. This does not include mechanisms used to assist a patient in obtaining and maintaining normative body functioning, for example, braces and wheelchairs.

Seclusion. A procedure that isolates the patient to a specific environmental area removed from the patient community.

Service. Used to indicate a functional division of a program or of the professional staff. Also used to indicate the delivery of care.

Shall. Used to indicate a mandatory standard.

Should. Used in a standard to indicate the commonly accepted method of compliance.

Social Assessment. The process of evaluating each patient's environment, religious background, childhood developmental history, financial status, reasons for seeking treatment , and other pertinent information that may contribute to the development of the individualized treatment plan.

Social Worker, Qualified. An individual who is licensed in the State with a master's degree from an institution accredited by the Council on Social Work Education, and is clinically qualified by training with two years experience in working with mentally ill children/adolescents.

Speech Screening. A process that may include such tests as articulation in connected speech and formula testing situations; voice in terms of judgments of pitch, intensity, and quality and determinations of appropriate vocal hygiene; and fluency, usually measured in terms of frequency and severity of stuttering or dysfluency (based upon evaluation of speech flow-sequence, duration, rhythm, rate, and fluency).

Support Staff. Employees or volunteers whose primary work activities involve clerical, housekeeping, security, laboratory, recordkeeping, and other functions necessary for the overall clinical and administrative operation of the facility.

Teacher, Qualified. An individual licensed and who has at least a bachelor's degree in education from an accredited institution. The individual shall have certification in special education, and preferably shall have training in the education or emotionally disturbed children/adolescents.

Therapeutic Recreational Services. Goal-oriented activities designed to help an individual develop expressive and/or performance skills through participation in art, crafts, dance, drama, movement, music, prevocational, recreation, self-care, and social activities.

Transfer. Movement of a patient from one treatment service or location to another.

Utilization Review. The process of using predefined criteria to evaluate the necessity and appropriateness of allocated services and resources to assure the facility's services are necessary, cost efficient, and effectively utilized.

Vocational Assessments. The process of evaluating each patient's past experiences and attitudes

toward work; current motivations or areas of interest; and possibilities of future education, training, and/or employment.